Addressing HIV and AIDS in Ugandan CSOs

Applied Research, End report

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STOP AIDS NOW!

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July 2009

STOP AIDS NOW!

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Acknowledgements

We wish to acknowledge the willingness of the (ex) members of the local project group, including the focal point persons of the lead organizations, to spend a long day with the applied research team to share their experiences and plans for the future. It requires courage to openly conduct a self-SWOT (Strengths, Weaknesses, Opportunities, and Threats) analysis, like they did. We thank the CSOs that participated in this review and made time for us on very short notice: TPO, Hospice Africa Uganda, NUWODU, EASSI, LABE, Health Need Uganda, FURA, and UFFCA. Fredica Baguma, Peter Wabukala, and Charles Kabiswa are appreciated for their outstanding contributions and input towards data collection and the completion of this end of study report. Without them this report – and the other four applied research reports – would not have materialized. Peter Nyango and Robina Namara are appreciated for quantitative data analysis and typing respectively. Special thanks go to staff of the STOP AIDS NOW! Project Uganda, Alex Tweheyo and Doreen Otim, for their technical input and for organizing appointments.

Abbreviations

ABC	Abstinence, Being faithful, Condom use
AIC	AIDS Information Commission
AIDS	Acquired Immunodeficiency Syndrome
AR	Applied Research
AR1 (2, 3)	Applied Research Phase One (Two, Three)
ART	Anti-Retroviral Therapy
DAC	District AIDS Commission
FBO	Faith Based Organization
FGD	Focus Group Discussion(s)
FUE	Federation of Ugandan Employers
GIPA	Greater Involvement of People with HIV and AIDS
HE	Health Education
HIV	Human Immunodeficiency Virus
HRM	Human Resources Manual
IEC	Information, Education, and Communication
ILO	International Labour Organization
JCRC	Joint Christian Research Council
M&E	Monitoring and Evaluation
MOH	Ministry of Health
MOU	Memorandum of Understanding
MTCT	Mother to Child Transmission (of HIV)
OI	Opportunistic Infections
PO	Participating organization (CSOs in STOP AIDS NOW! project)
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RTI	Research Triangle Institute
TOR	Terms of Reference
UAC	Uganda AIDS Commission
VCT	Voluntary Counselling and Testing
NGO	Non-Governmental Organization
OI	Opportunistic Infections
PC	Project Coordinator
PO	Participating organization (NGOs in STOP AIDS NOW! project)
PLHIV	People Living with HIV
PMTCT	Prevention of Mother to Child Transmission (of HIV)
RTI	Research Triangle Institute
SAN!	STOP AIDS NOW!
TOR	Terms of Reference
UAC	Uganda AIDS Commission
VCT	Voluntary Counselling and Testing

Executive Summary

The report focuses on specific themes that are important in the development and implementation of HIV and AIDS workplace policies: the project structure and its approach, social networking, access to services, involvement of people living with HIV and AIDS (PLHIV), the influence of internal mainstreaming on external mainstreaming, stigma and discrimination reduction, and spill-over effects.

Methodology

The report is based on findings from the three applied researches (AR) that were aimed at providing policy makers, programme staff, and beneficiaries in the STOP AIDS NOW! partner organizations with information about how to direct or redirect activities for successful workplace policy development and implementation. The three phased AR concerned:

1 CSOs developing workplace policy (June to December 2006)
2 Start of implementation (January to June 2007); and
3 Implementation and effects (July 2007 to June 2008). Additional information for this report was collected through key informant interviews with CSO directors and HIV and AIDS focal point persons and a workshop with members of the local project group.

Findings

Overall, the STOP AIDS NOW! project has been successful, with 50 out of the 76 CSOs having developed and (partly) implemented a workplace policy. At the time of the 2006 baseline, only 4 CSOs had a final workplace policy, and 14 a draft workplace policy.

Project structure

The STOP AIDS NOW! Uganda project structure includes the local project coordinator's office, based in the host organization ACORD in Kampala, the local project group, and the three regional lead organizations (lead organisation), which were to provide capacity building, supervision, and guidance to CSOs. The Uganda project receives advice from the Dutch project coordinator. Programme officers of STOP AIDS NOW! donors (ICCO, Cordaid, Oxfam Novib, and Hivos) support individual partner CSOs.

The STOP AIDS NOW! project structure is generally valued for its local ownership and management. The local project group, which acts as the project's steering group, consists of 8 established CSOs with capacity concerning HIV and AIDS, and experience in HIV mainstreaming. Their wide networks also serve as an advantage. Overall the local project group is able to carry out their responsibilities as described in the terms of reference – although membership of individual CSO officers is not stable. The lead organisations also carry out their responsibilities, but their main self reported *weakness* is that they lack time for their work to conduct training and supervisory visits to the CSOs in their region. Moreover, not all lead organisation focal point persons have sufficient technical ability because of high staff turnover.

CSOs greatly appreciated the support provided by the project coordinator and lead organisations. This included technical support, support during training and supervision visits, and support in the provision of IEC materials and sometimes condoms. The supervisory role of the project coordinator was found to be especially important when organizations were doing the budgeting.

Supporting STOP AIDS NOW! documents

The two supporting STOP AIDS NOW! documents are the Good Donorship Guidelines and the budgeting tool What's it likely to cost?, which provide direction on how to develop a workplace policy and an accompanying budget respectively, as well as what support can be expected from the STOP AIDS NOW! donor agencies. Overall, CSOs were aware of the Good Donorship Guidelines, but less of the budgeting tool, and not all had read the whole documents. They complained that the documents are too long – with Uganda 'not having a reading culture'. Those who were aware of and had read the documents said that the guidelines were useful and that they had used them. The commitment of donors to pay an amount up to 4% of staff salaries towards the workplace policy was the commitment in the Good Donorship Guidelines remembered by most, but was also an issue which most organizations had problems with; they said that if the salary of staff is low then the 4% is a very small amount and not adequate to cover many activities. Suggestions from the local project group are for STOP AIDS NOW! to repackage the Good Donorship Guidelines and What's it likely to Cost? tools into simpler ones for use by organizations.

STOP AIDS NOW! project database

The STOP AIDS NOW! project information database serves as a tool for project management and for CSOs to monitor their activities and progress. Every quarter CSOs digitally feed information into their own CSO page of the information database – a task usually performed by the focal point person as he/she was trained to. Most CSOs opined that the database is user friendly, and that it helps them to know what progress they have made. One problem identified in the information database audit in 2008, however, was that not all CSOs always fill in the information database on time, which makes collating reports difficult. Suggestions made included:

1 Try to make it more attractive – for instance on the home page provide a weekly information update, including links and downloadable reports; and
2 Give more feedback to CSOs about what they and other organizations are reporting in the database.

HIV and AIDS focal point persons

Focal point persons in CSOs play pivotal roles in workplace policy development and the implementation of activities. They are the link between the CSO, lead organisations, and the project office. He or she is a staff member, appointed by CSO management, usually on part-time basis. Nearly all organizations which have started the process of workplace policy development have an focal point person. Main activities normally include:

- Establishing and maintaining the HIV and AIDS corner and the first aid kit
- Organizing HIV talks for staff
- Providing condoms
- Guiding staff where to access HIV related services; representing organizations in meetings regarding workplace policy; and
- Organizing internal and external workplace policy events, for instance VCT days.

Most of the focal point persons have received STOP AIDS NOW! training – especially in using the STOP AIDS NOW! information database. The main challenges which focal point persons face are:

1 Balancing organizational work with the STOP AIDS NOW! focal point person work
2 Changes in focal point persons due to staff changing jobs or roles – and consequently a lack of technical know-how.

Capacity building and its effects

Capacity building – by training, workshops, and support visits – is an important strategy used to get CSOs and stakeholders motivated and involved. Workshops, moreover, provide the opportunity to exchange experiences between CSOs. STOP AIDS NOW! training started with a sensitization of directors and senior managers workshop in June 2005. The workshop objectives were to create harmony and alignment among STOP AIDS NOW! partners for the project, to sensitize directors for the need to address HIV and AIDS in their workplace, and for them to learn about the basic ingredients of how to formulate a workplace policy. Then several two day workshops on peer education and workplace policy development took place in October 2005 and the first months of 2006, in the three regions. Participants were mainly focal point persons, but managers and some directors also attended. In 2007, focal point persons were trained in the 12 box model tool for organizational self assessment regarding HIV and gender sensitive workplaces. In 2008 focal point persons and other representatives received training on how to fill in and use the STOP AIDS NOW! information database.

Capacity building of staff was conducted in all CSOs that started the process of workplace policy development. This started with the sensitization of staff through routine discussion or training, and Information, Education, and Communication (IEC) materials on HV and AIDS were provided in most offices. Managers feel that a lot of awareness on HIV and AIDS has been created among staff through the workplace policy related activities. Awareness is related to knowledge of HIV and AIDS 'basics', but also of the workplace policy, the importance of VCT and disclosure, and of the proper attitude that should be taken towards people with HIV and AIDS, i.e. not stigmatizing or discriminating against them. Staff also reported increased knowledge about HIV and AIDS because of workplace policy activities – 67.4% in AR3. As a result of this raised knowledge and awareness, staff and managers reported more open discussions on HIV and AIDS in the workplace, improved attitudes towards people living with HIV (PLHIV), behavioural changes (especially safer sexual behaviour), and more motivation to go for VCT.

Involvement of PLHIV

The STOP AIDS NOW! project promotes involvement of PLHIV in all its activities. PLHIV have featured either:

1 *Passively*, as motivation for CSOs to develop a workplace policy; or
2 In an *active role*, by being members of the local project group, facilitating during workshops, in advocacy to make staff aware of HIV and AIDS, and promoting positive living.

Having (had) staff living with HIV or who died was cited as one of the main motivations for CSOs to develop a workplace policy. The fact that 71% of staff (AR1) was found to be personally affected by HIV and AIDS, and 57% felt there is an affect of HIV on the workplace, helped to motivate staff to participate in workplace policy activities.

Sustainability

The interventions of the STOP AIDS NOW! project seem to be sustainable. Though the three year. STOP AIDS NOW! pilot project has come to an end, the local project group through ACORD received an extension for two years, as a consortium with funding from the Civil Society Basket Fund (CSF). Most CSOs with workplace policies reported having measures in place to sustain their workplace policies once STOP AIDS NOW! donor support stopped. Sustainability strategies include training their own peer educators, writing proposals for funding, mainstreaming HIV and AIDS in other organizational budgets, and internal fundraising mechanisms. A challenge to the sustainability of workplace policies in organizations, mentioned by the local project group chair, is loss of institutional memory and thus enthusiasm; because of staff turnover, new executive managers and directors may not be aware of or motivated to manage HIV in the workplace, and so would not support the focal point person by allocating time and funds.

Linking and learning and social networking

Linking and learning has taken place at various levels, by project management and CSOs, for education, training, and services. A multi stakeholder approach is a project strategy that aims to always involve relevant government institutions, international and national CSOs, UN agencies, and the private sector in STOP AIDS NOW! workshops and activities. The 76 STOP AIDS NOW! partner organizations form a social network through which members exchange information and experiences, especially during training and by participating in events. In AR2 most participating organizations reported having established links with other organizations and service providers beyond the STOP AIDS NOW! network, for example, they were found to be networking and collaborating with training institutions, service providers, information organizations etc., and this facilitated the implementation of their policy with minimal cost.

Access to services

Through the workplace policies staff access to HIV and AIDS services has been facilitated. Which services would be provided by the CSO was often a point of discussion when developing a workplace policy. CSOs feared the financial implications of a commitment in the workplace policy to providing access to ART and treatment of opportunistic infections. Provision of condoms for staff has also been a contested issue, especially in faith based organizations (FBOs). The project office, local project group, and lead organisations facilitated access for partner CSOs by linking them to services, building the capacity of CSO staff to provide services (for instance counselling), or by physically bringing materials (IEC and condoms) during supervision visits. CSOs now facilitate access to services for their staff, in particular IEC, counselling, condoms (66% of staff in AR3 had access), VCT, ART and health services, and care and support.

Influence of internal mainstreaming on external mainstreaming

CSOs which do not have health or AIDS as their (core) business were found to have started or intensified discussion about HIV and AIDS with their beneficiaries, and some had tried to mainstream HIV and AIDS in their programmes. Participating in the workplace policy activities helped staff to be knowledgeable and conversant with HIV and AIDS issues, including in their work with beneficiaries. It was recognized by focal point persons that external mainstreaming does not have to cost extra money, because it becomes an integral part of the projects.

Stigma reduction

Feared stigma and discrimination have reduced because of the participatory development of workplace policies and various workplace policy activities: 55% of staff (AR3) reported a change to having a more understanding attitude towards PLHIV. Sensitization and awareness raising sessions, undertaken by all CSOs as a first workplace policy activity, created more knowledge and openness concerning HIV and AIDS among staff; 64% of staff felt there is more openness to talk about HIV and AIDS with their fellow workers. This openness has also led to more staff members expressing their intension to disclose their status in the workplace if they found themselves to be HIV positive, indicating that they do not fear stigma: 50% said they would now disclose their status, 15% said they would already have disclosed, while 38% would still not disclose. Staff also trust that they will be supported: almost all staff (88%) are now confident they would not lose their job if HIV positive (AR3).

Spill-over effects

Workplace policy discussions and activities seem to reach out to the social network of staff, even without intentionally involving them, such as is done during VCT days, or when also allowing family members to receive benefits through the workplace policy. The knowledge that staff gained from IEC sessions was reportedly shared with family and friends – the majority (90.2%) of the 123 staff in AR3 who had received training said they shared what they had learned with others. However, it is not only information which is shared outside the office but also condoms: AR3 found that staff who take condoms do not necessarily use them themselves, and managers also reported that they suspect that staff take condoms for others.

Recommendations

To CSOs

- Continue with internal awareness raising on the workplace policy and IEC, focusing on issues which staff would like to know more about
- Provide all new staff with a copy of the workplace policy, and explain the contents
- Start/continue implementing workplace policy activities that do not require much funds
- Link with services, IEC, and training institutions; be keen to identify free services
- Specify the job description of the focal point person with attached time allocation
- Internally share what has been gained in training of individual staff. For instance, internally train more peer educators.

To local project group and Project Coordinator

- Rotate part of the membership of local project group
- Provide more training to the focal point person of the lead organizations and provide more funding
- Call future STOP AIDS NOW! training 'training of trainers'
- Organize refresher training for new CSO staff
- Continuous sensitization of CSO senior managers and directors
- Repackage Good Donorship Guidelines and budgeting tool What's it likely to cost? into simpler formats for use by organizations, e.g. CDs, leaflets, posters, etc.
- Improve use and functions of the information database – by making it more attractive and by giving more feedback to CSOs.

To STOP AIDS NOW! donors (Oxfam Novib, Hivos, Cordaid, and ICCO)

- Screen submitted budgets in a timely fashion and release funds promptly to allow the Ugandan CSOs to implement their workplace policy programme activities
- Initiate new programme managers in workplace policy at the start of their job
- Share lessons learnt and promising practices identified from this project with other agencies/ countries.

To STOP AIDS NOW! – Dutch project coordinator

- Be at the forefront to identify, link, and negotiate for further/continued funding from other donors
- Share lessons learnt and promising practices with other agencies and in other countries.

To (future) similar projects

- Establish a local project group; membership should comprise of credible organizations with useful networks and different fields of expertise
- Install lead organisations if the country is too big or partner CSOs too many. lead organisations should be credible and established organizations with strong networks
- Create guidelines and memorandum of understandings for all the stakeholders; review them periodically
- Involve key stakeholders right from the inception and design stage. These should include national level stakeholders, e.g. National AIDS Commission, Ministry of Health, ILO, CSOs, associations, organizations of PLHIV, organizations of employers, etc.

1 Introduction

This report presents the experiences of a three year STOP AIDS NOW! project addressing HIV and AIDS in 76 CSO workplaces in Uganda, and focuses on some specific themes that are important in the development and implementation of HIV and AIDS workplace policies. The report will pay attention to promising practices but also to challenges – both of which can serve as lessons for present and future stakeholders in HIV and AIDS workplace policy programs. This introductory chapter sets the context and the background of the project in Uganda and introduces the study questions for this report.

1.1 HIV and AIDS in Uganda

Despite the declining trends in its prevalence, HIV and AIDS are still a major health and socio-economic probiem in Uganda. In 2006, the cumulative number of Ugandans infected with HIV was estimated at 2.3 million. The number of new infections continues to outstrip the number of deaths due to HIV infection; an indication that prevention efforts are failing to keep pace with the epidemic. Since the identification of the first AIDS cases in Uganda in 1982, HIV has spread throughout the country resulting in a severe, mature, and generalized epidemic. The HIV prevalence rose sharply between 1989 and 1992, peaking at an average rate of 18%, which then declined between 1992 and 2002, stabilizing at between 6.1% and 6.5% between 2002 and 2005. Hladik et al.[1] estimated that by December 2005 there were a total of about 915,400 people living with HIV and AIDS, of whom 530,932 (58%) were women and 109,000 (12%) were children under 15 years. A total of 67,000 (34.6%) AIDS patients were on ART out of 194,900 who needed them, meaning that 127,500 HIV positive individuals who required ART were not receiving them.[2]

1.2 HIV and AIDS as a workplace issue

Despite the effectiveness of available interventions, the global and national burden of HIV continues to grow. UNAIDS estimates that there were a total of 33.2 (30.6 – 36.1) million people living with HIV, 2.5 (1.8 – 4.1) million new infections, and 2.1 (1.9 – 2.4) million deaths due to HIV by December 2007 (UNAIDS 2008). It is projected that by 2020, the workforce in high prevalence African countries will be between 10 to 30 per cent smaller than those without high AIDS rates (ILO 2006).[3] As the number of people with HIV increases, and improved treatment extends the years of life without symptoms, there will be more employees with HIV infections who will continue to work (although hopefully addressing HIV in the workplace will also prevent new infections). This trend indicates that many workers are already coping with or will have to cope with HIV and AIDS. As an employer, there is a need to consider initiation, formulation, and implementation of a workplace policy that focuses on management of HIV and AIDS at the workplace.

The ILO *Code of Practice on HIV/AIDS and the World of Work* (2003) sets out the fundamental principles for policy development and practical guidelines for concrete responses. These include prevention of further spread of HIV, mitigation of the socio-economic impact of HIV and AIDS, care, treatment and support, stigma and discrimination reduction, promoting gender equality, and confidentiality.

[1] Hladik W, Musinguzi J, Kirungi W, Opio A, Stover J, Kaharuza F, Bunnell R, Kafuko J, Mermin J. 2008 (Feb 19) The estimated burden of HIV/AIDS in Uganda, 2005-2010. AIDS 22(4):503-10.

[2] Wabwire-Mangen 2008. Modes of Transmission Study: Uganda: A Review of the Epidemiology of the HIV/AIDS epidemic. Makerere University.

[3] www.ilo.org/public/english/protection/trav/aids/publ/global_est06/global_estimates_report06.pdf

An HIV and AIDS workplace policy provides a direction on how to protect, care for, and support workers and their families affected and/or infected by HIV and AIDS. In addition, an HIV and AIDS policy defines an organization's position and practices for preventing HIV transmission and for responding to HIV infection among staff. The policy provides guidance to managers who deal with the day to day issues and problems that arise in the workplace, and also informs staff about their responsibilities, rights, benefits, and expected behaviour on the job.

1.3 Effects of HIV and AIDS on Workplaces in Uganda

HIV and AIDS have negatively impacted practically all sectors in Uganda, thus affecting work performance. It affects adults in their prime productive years, and morbidity and mortality due to HIV and AIDS affect workplaces through absenteeism and loss of skilled or trained employees. Ministries, CSOs, and the private sector have registered an increase in death of staff, sickness, opportunistic infections, low productivity, and inefficiency due to absenteeism, with further increases in expenditure on training to replace deceased staff, sometimes involving the diversion of limited resources to care for the sick workforce.

As the number of persons infected with HIV continues to increase, organizations ought to assume a critically important role in prevention efforts, and can create a favourable environment for employees infected and living with HIV by formulating and implementing policies that focus on managing HIV and AIDS in the workplace. The Ugandan government ratified the ILO Code of Practice on HIV and AIDS and the world of work, and is working towards its implementation. In Uganda, a number of organizations have developed HIV and AIDS workplace policies, which are currently being or are still to be implemented. For instance, the Public Service HIV and AIDS Policy (2004) upholds the public health rationale for respecting the human rights, privacy, and self-determination of PLHIV, their responsibility to protect others from infection, and the right of society to that protection. The policy places emphasis on protection against discrimination, equal rights and obligations, information, education and communication, confidentiality, voluntary testing for HIV, and against deliberate transmission of HIV and AIDS. The Parliament of the Republic of Uganda has developed a Parliamentary HIV and AIDS Communication Tool Kit that intends to give political leaders a working knowledge of the main HIV and AIDS issues and interventions in Uganda to facilitate informed, open, non-prejudiced, non-judgemental, non-stigmatizing, and non-discriminating communication about the epidemic. The Local Government HIV and AIDS Plan (2000) sets out to strengthen staff welfare, sensitization and advocacy, training and education, health services, community laws/bylaws, resource mobilization, planning, co-ordination, and implementation. The plan focuses on mainstreaming HIV and AIDS activities in the development programs for all local governments.

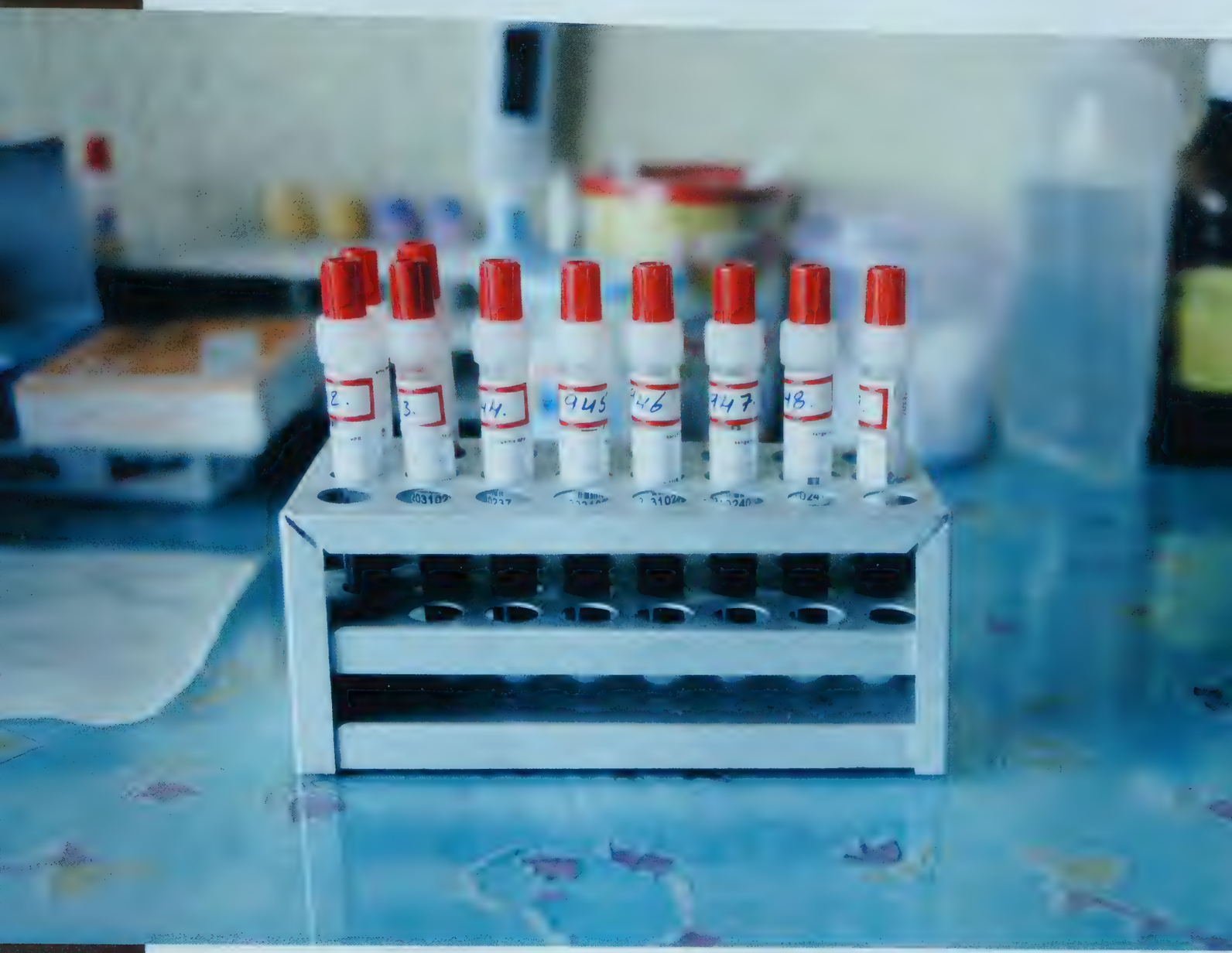
1.4 STOP AIDS NOW! Project 'Managing HIV and AIDS in the Workplace'

The STOP AIDS NOW! project 'Managing HIV and AIDS in the Workplace' was intended to support STOP AIDS NOW!'s partner organizations in the South in developing and implementing policies on HIV and AIDS in the workplace. This project was developed under the theme of 'Access to Treatment'. AIDS is not a disease that CSOs can ignore; it directly affects their workforce and their workers' families. Donors, for their part, have to acknowledge the reality of a possible increase in expenses and decreased productivity of their partners in the South due to HIV and AIDS, and consider how they can (continue) support their partners working in these conditions.

The STOP AIDS NOW! project 'Managing HIV and AIDS in the Workplace' consists of three sub-projects: a) developing Good Donorship Guidelines, and implementing them; b) supporting partner organizations in three countries, Uganda, Ethiopia, and India, in the development and implementation of HIV and AIDS workplace policy; and c) providing linking and learning events between the sub-projects, different partners, and different countries.

1.5 STOP AIDS NOW! Project 'Managing HIV and AIDS in the Workplace' in Uganda

The main objective of the STOP AIDS NOW! project 'Managing HIV and AIDS in the Workplace' in Uganda was to Facilitate 76 Ugandan CSOs, partner organizations of STOP AIDS NOW! partners – Oxfam Novib, ICCO, Cordaid, and Hivos – to develop and implement HIV and AIDS workplace policies, or to address HIV and AIDS in the workplace in other ways.



The inception of the STOP AIDS NOW! project in Uganda took place in June 2005 with a sensitization workshop for directors of partner organizations and other strategic partners (i.e. organizations that were not necessarily funded by STOP AIDS NOW! partners, but had experience in workplace policy). The workshop objectives were to create harmony and alignment among STOP AIDS NOW! partners for the project, to sensitize directors to the need to address HIV and AIDS in their workplace, and for them to learn about the basic ingredients for formulating a workplace policy. Ugandan organizations that already had a workplace policy presented how their workers and organization were affected by HIV and AIDS, and how they addressed the problems in their workplace. A male and female volunteer from the National Forum of People living with HIV and AIDS in Uganda (NAFOPHANU), both living with HIV and AIDS themselves, shared experiences on stigma and discrimination, and participants were introduced to an anti-discrimination toolkit from which they did an exercise. During the workshop, the STOP AIDS NOW! project coordinator based in the Netherlands introduced the project initiative, and plans for locally managing it. Workshop participants contributed to formulating the terms of reference for the local project group and the local project coordinator; this was to enhance a sense of ownership.

Later, in June 2005, strategic partners met to set up the Ugandan project structure and to further define the terms of reference for the local project group and project coordinator. They decided that the local project group would be chaired by CDRN, and that ACORD-HASAP would host the project coordinator. Members of the local project group were agreed as CDRN, ACORD-HASAP, TTP, UCS, Concern Worldwide, HNU, and Oxfam GB. To ensure the greater involvement of PLHIV, NAFOPHANU was invited to sit on the local project group, and accepted (although they are not one of the STOP AIDS NOW! partner organizations). The local project group meets every two months and

they have to approve the six month project work plans, review project documents – such as the monitoring and evaluation framework – and give technical and strategic direction to the project and the project coordinator. The official launch of the project was in November 2005.

After the first draft workplace policies were received, a policy review committee was installed to review them. Members included the project coordinator, HNU, FURA, ILO, FUE, CDRN, NAFOPHANU, and ACORD-HASAP. They used specially developed review guidelines, in accordance with those of the ILO.

Partner organizations are too numerous and too widely spread for the project coordinator alone to cover through field visits. Instead, organizations in each region selected one of their peers to be the lead organization, based on the criteria of willingness, accessibility, location, human infrastructure, and time availability. FURA was selected in the West and HNU for the Northeast. Their duties were to collect (draft) workplace policies, monitor and report progress, and give technical advice. Later, in 2007, TPO Uganda was identified as lead organisation for the central region.

The project coordinator from the Netherlands gives technical and organizational (networking) advice and support to the project coordinator and local project group by email and regular visits to Uganda. She is backed by the project coordination group in the Netherlands, which is chaired by Oxfam Novib. Members of the project coordination group are program officers and policy officers from STOP AIDS NOW! partners. The Good Donorship Guidelines document has been developed so that the Dutch donor CSOs commit themselves to contribute financially and technically to the workplace policy implementation of their Ugandan partner organizations.

Technical support and capacity building takes place through technical support visits by the project coordinator and lead organizations and through training, workshops, and learning events. Capacity building is one of the special themes that will be highlighted in this report.

In March 2006, a baseline study was conducted of 52 CSOs. They interviewed 52 directors and managers, and did 27 focus group discussions with other staff. The overall aim of the study was to assess the status on managing HIV and AIDS in the workplace in these organizations, and to identify opportunities and constraints for development of workplace policies. Most managers and staff members recognized HIV and AIDS to be a threat to the workers and to the organization, however, only a few organizations had structurally addressed HIV and AIDS in their workplace; 4 had a workplace policy and 14 a draft workplace policy. Mechanisms for dissemination of HIV and AIDS specific information appeared almost non-existent. Thirty of the 52 organizations had HIV and AIDS focal point persons, but no organization had scheduled discussions on HIV and AIDS in their work plans. Although 21 out of 52 organizations had health schemes for members of staff, and some for family members as well, most did not include access to ART. Workers appeared to have a general knowledge on HIV and AIDS, but mentioned a lack of specific knowledge on VCT, PMTCT, and ART. Most employees said they did not discriminate against PLHIV, but at the same time many admitted that they would not want to disclose their status because of feared stigma.

1.6 Applied Research

Part of this pilot project was an applied research (AR) with the aim to provide policy makers, programme staff, and beneficiaries in STOP AIDS NOW! partner organizations with information about how to direct or redirect activities for successful workplace policy development and implementation. Furthermore, the AR was to document, analyse, and report on promising practices and lessons learnt for similar future workplace policy projects. Specific in this AR is that it was designed as a multilevel study, i.e. looking at project level, CSO level, and staff level.

The AR was conducted in three phases: the first (AR1) concerns CSOs developing policies (June to December 2006), the second (AR2) the start of implementation of policies (January to June 2007), and the third (AR3) the implementation and effects (July 2007 to June 2008). The objectives, methodologies, and study populations are explained below per phase. (Annex 1 lists the CSOs that were involved in each phase).

The research team consisted of two principal investigators – from Makerere University, Kampala, and from the University of Amsterdam, the Netherlands – who were responsible for study design, analysis, and reporting. Four researchers co-designed the data collection tools, collected the data, and worked on data handling and analysis. A statistician was responsible for entry of quantitative data and analysis, while three secretaries transcribed and typed the qualitative data.

1.7 Study questions of the final AR report

This being end of project review, we were interested in understanding how the project has contributed to the goals and objectives it set out to achieve. The main questions asked related to whether the STOP AIDS NOW! project structure, design, and guiding documents adequately supported and facilitated the desired results of workplace policy development in CSOs. The aim of this review is to learn from promising practices and challenges, and so provide recommendations for future projects for workplace policy development and implementation. The review especially focuses on some themes and issues of vital importance in workplace policy projects, and for this some additional information had to be collected by the AR team – in January and February 2009.

The following are the detailed study questions, relating to the main themes of interest:

1 **Project structure**
Does the STOP AIDS NOW! project design and structure adequately support and facilitate the desired results of workplace policy? What have been the practices and constraints of the project support structure? How do different levels of support and management evaluate their own role and practices? What have been the strengths, weaknesses, opportunities, and threats (of project coordinator, local project group, lead organisations)?

2 **STOP AIDS NOW! documents and monitoring and evaluation**
How useful are the supporting documents *Good Donorship in a time of AIDS , What's it likely to cost,* and the project information data base?

3 **HIV and AIDS focal point person**
What have been the roles of the focal point persons in development and implementation of workplace policy? Which conditions have facilitated or constrained their role?

4 **Capacity building**
How useful have the capacity building activities in the STOP AIDS NOW! project been for developing and implementing workplace policy, as perceived by the trainees at CSO and staff level?

5 **Involvement of PLHIV**
How have PLHIVs been involved in the project (at project level and within organizations)?

6 **Sustainability**
To what extent is the project sustainable – both as STOP AIDS NOW! project and the workplace policies at organizational level? What measures have organizations and the local project group put in place for sustainability?

7 **Linking and learning**
How has the project facilitated linking and learning and social networking? What are the types of social networks created, with whom, for what purpose, and how have they been facilitated (at project and CSO level)?

8 **Access to services**
How has the workplace policy influenced/ facilitated access to services for staff members (IEC, counselling, prevention (condoms), VCT, ART, care and support)?

9 **Stigma**
How has HIV related stigma been influenced by the workplace policy?

10 **External mainstreaming**
How has the internal mainstreaming (workplace policy development and implementation) influenced external mainstreaming (the work in the communities)?

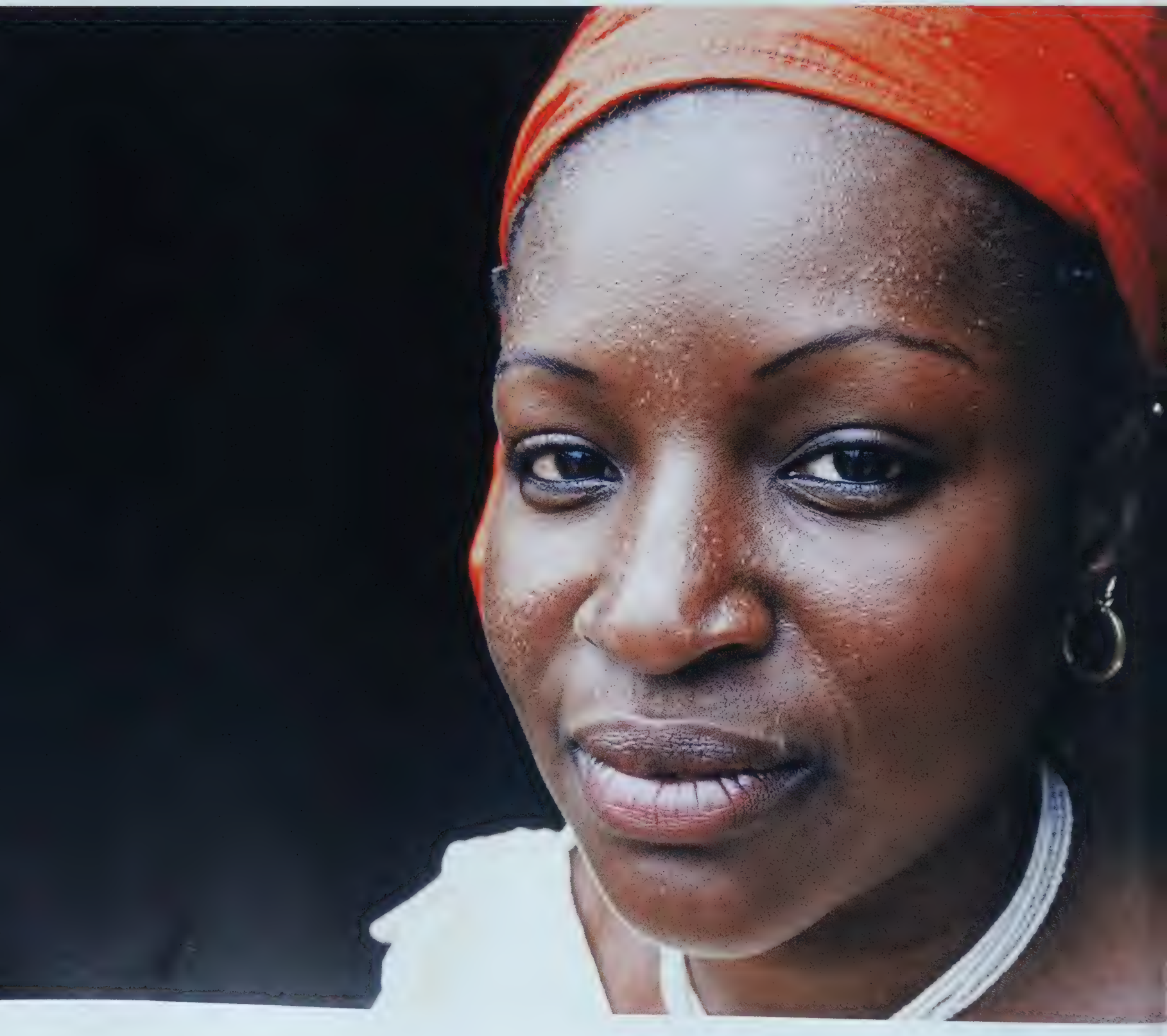
11 **Spill-over effects**
What are the spill-over effects of workplace policy activities (to the social network of staff)?

1.8 Report structure

After this introductory chapter the report comprises of five further chapters. Chapter 2 describes the study methodology, after which Chapter 3 presents a summary of findings of the three phases of the AR. This summary is divided into the sections Initiation, Development of workplace policy, Implementation, and Effects respectively. In the summary there will be little attention to the findings on special topics of this final review, which will be addressed in Chapters 4 and 5. Chapter 4 zooms in on the STOP AIDS NOW! structures and approach (study questions 1 to 6), whereas Chapter 5 focuses on the specific topics of social networking, access to services, the influence of internal mainstreaming on external mainstreaming, stigma, and spill-over effects. In Chapter 6 the lessons learnt from the STOP AIDS NOW! Uganda project will be analysed: the promising practices and the challenges. The report is rounded off with recommendations to various stakeholders who are interested in workplace policy development and implementation.

2 Methodology

After formulating the study questions for this review, for each question the sources of information were identified – as much as possible, existing data from the three AR phases and project documents were used, but after the first screening the research team concluded that some additional data had to be collected for some of the themes. This chapter explains the methods of data collection and the sources of information.



2.1 Methods of data collection and sources of information

The end review utilized mainly qualitative methods of data collection through:

1 Documents review
2 Key informant interviews, and
3 A workshop.

2.1.1 Documents review

In January 2009, the AR team screened the *four AR reports* and *AR raw data*, and *STOP AIDS NOW! project documents* for information on the specific themes. All information was mapped in a template and analysed for completeness. It appeared that information for some themes and at some levels (project, CSO, staff) was fairly complete, while for others it was insufficient or lacking. Information at staff level was sufficient, while information was especially scarce on involvement of PLHIV, the influence of internal on external mainstreaming, (self-evaluation of) STOP AIDS NOW! project structure, and sustainability at project level (though for CSO level there was sufficient information). Some information was extracted from two *master study theses* on workplace policy in four CSOs: TPO, FURA, Health Need, and KARUDEC (Westerhof 2008; Huson 2008)[4].

2.1.2 Key informant interviews

Key informant interviews were conducted with managers and focal point persons in 8 purposively selected partner CSOs: TPO, Hospice Africa Uganda, NOWUDU, EASSI, LABE, Health Need Uganda, FURA, and UFFCA. These CSOs were selected with help of the STOP AIDS NOW! project officers because they were available and could share promising practices. Furthermore, in-depth interviews were conducted with the local project group chairman and the former project coordinator(who left in October 2008).

2.1.3 Workshop with local project group members

A one day workshop was conducted with 16 participants. Thirteen were (ex)members of the local project group – they included the former local project group chairman, 3 who were local project group members since inception, and representatives from the three lead organizations. Three members of the AR team also participated. The objective of the workshop was to clarify the perspectives of local project group members on the STOP AIDS NOW! project and their role in it, and focus on certain themes for the end report. Procedures were participatory, with group work on answering certain questions related to the themes, and presenting group work results in plenary.

2.2 Data analysis and presentation of findings

Data from key informant interviews and the local project group workshop were transcribed and typed in Word documents. Information on themes in the AR reports and STOP AIDS NOW! project documents were also extracted by the AR team members and typed in Word documents. Then information from the different sources was clustered according to the thematic areas of the review and entered in a matrix. Manual data analysis of each theme was done by the two principal investigators.

Reporting is done by theme, presenting the information from different sources and at different levels (project, CSO, and staff) where applicable. AR1 refers to AR Phase 1, AR2 to AR Phase 2 and AR3 to AR Phase 3. Where needed it will be explained whether the findings relate to staff, CSO, or project level – with project level referring to the project office, project coordinator, local project group, and lead organisations.

[4] Huson, M. 2009. Managing HIV and AIDS on another level. Promotion of voluntary counselling and testing and stigma reduction through HIV and AIDS workplace policies in Ugandan CSOs. University of Amsterdam – Master Thesis for Medical Anthropology and Sociology. (available from STOP AIDS NOW! website).
Westerhof, N. 2009. Gender equality and stigma reduction in CSO workplace in Uganda. A study of the effects of HIV and AIDS workplace policies. University of Amsterdam – Master Thesis for Medical Anthropology and Sociology. (available from STOP AIDS NOW! website).

3 Summary of three AR reports

This chapter provides a summary of the methodology and findings of the three AR phases, in which we will concentrate on what motivated CSOs to address HIV and AIDS in the workplace, how they developed and implemented workplace policy, and what the effects were on staff and organizations. This chapter presents only outlines of the findings on the specific themes, and refers to Chapters 4 and 5 for in-depth information. In this summary, only a few cases are given – readers interested in these are hereby referred to the complete AR reports. Section 3.6 will pay attention to the use of the AR reports by the project and CSOs, focusing on whether and which recommendations were used in subsequent phases. This section will also reflect on some limitations of the studies.

3.1 Study methodologies

3.1.1 Phase one: Development of workplace policy

The first phase of the AR used two main data collection methods, at two levels. The first data set derives from a survey of 406 staff members in 60 partner organizations, using a semi-structured questionnaire to explore their personal views. The second set is a collection of case studies of 16 organizations on the process of developing a policy. For these case studies multiple interviews were conducted in each organization with different levels of staff. Data were collected in the period June to December 2006. The objectives of this phase were to:

- Provide a baseline of staff attitudes and knowledge related to HIV and AIDS
- Describe the process of developing workplace policies in CSOs
- Document and analyse promising practices and challenges
- Provide recommendations for workplace policy development.

3.1.2 Phase two: Start of implementation

Qualitative methods were used to collect data in the period April to July 2007. In-depth interviews were conducted with 92 managers and focal point persons in 72 organizations, and 24 focus group discussions were held with staff in CSOs with a draft or final workplace policy. Additionally, an focus group discussion was held with local project group members. The objectives of this phase were to:

- Document the process of workplace policy development
- Describe the (start of) implementation
- Identify promising practices, facilitating factors, and challenges
- Give recommendations for workplace policy implementation.

3.1.3 Phase three: Implementation and effects

In this last AR phase the effects of workplace policy implementation were studied at CSO and staff level in a sample of organizations that had workplace policies. Data collection took place between March and August 2008 through two methods: face to face interviews with 236 staff members in 31 CSOs using a semi-structured questionnaire, and in-depth interviews with managers of 29 CSOs. The objectives of this phase were to:

- Describe and analyze implementation and effects of HIV and AIDS workplace policy
- Document CSOs' experiences with STOP AIDS NOW! support structures
- Identify promising practices, facilitating factors, and challenges
- Give recommendations for workplace policy implementation.

3.2 Initiation of and motivation for workplace policy

The case studies of 16 CSOs in AR1 showed that the regular STOP AIDS NOW! training, supervision, and research activities boosted take-off and activities within organizations. Through seminars and workshops participants were sensitized to the need to address HIV and AIDS in the workplace, but also learnt skills about how to develop a workplace policy. The sensitization and inclusion of senior management and directors at the initiation seminar in June 2005 was important for the project. The (re)initiation of the workplace policy development process usually occurred after these STOP AIDS NOW! capacity building workshops, when staff returning from them briefed colleagues in regular staff meetings and it was decided to start the process.

An important motivation for workplace policy development was found to be when organizations have been directly affected by HIV and AIDS, have (openly) HIV positive staff member(s), or a staff member who had died of AIDS, as 6 CSOs had in AR1. Other organizations were indirectly affected because staff had to take time off to provide care and to attend burials. Managers said they help(ed) the sick and affected staff in an ad hoc manner, and staff members out of good will may also contribute something. Having seen co-workers die of AIDS particularly motivated management and staff to address HIV and AIDS in the workplace.
A motivation for CSOs to develop a workplace policy also comes when they realize staff are at risk – although not infected yet – and this may affect the CSO. Especially for CSOs which have activities that require staff members to travel for long periods to the field or to workshops recognize the risk this entails for casual sexual relations, either with community members or between co-workers when staff of different sex travel together. The AR1 baseline survey of 406 staff showed that a considerable number (32.2%) felt at risk of HIV in the workplace or during duty travel.

In AR2, when more CSOs were studied, similar motivations were mentioned for starting the workplace policy process, including the need for guidelines to care for and support infected staff, but also some additional ideas, including the need to address stigma and discrimination in the workplace, and to raise HIV and AIDS awareness among workers. In AR2, the were also studied, and these were found to include financial constraints, lack of technical guidance, labour turn over (especially for the key staff involved in the policy), and having the idea that staff members were too few. These reasons were provided by 10 CSOs which were interested in workplace policy, but had not yet started implementation. The two organizations that said they were not interested gave as reasons that they will start in their own time and not through the STOP AIDS NOW! project, and that it is not in their interest for HIV positive staff to disclose their status in the office.

3.3 Development of a workplace policy

AR1, which studied the development of workplace policy in organizations in depth, found that most (14 out of 16) developed their policy in a participatory way with involvement of different levels of staff – as is recommended for purposes of ownership and commitment. Most formed a committee (of between two and ten staff members) to develop a draft workplace policy. For the policy writing, the committees used the information and materials from the STOP AIDS NOW! workshops and documents downloaded from the internet, from ILO, and Centres for Disease Control. Some asked for additional information from the project coordinator or the Federation of Ugandan Employers (FUE). The committees then typically circulated the draft, in hard or soft copy, to other staff for written comments, or called a special staff meeting to discuss the draft.

In some organizations, just one person wrote the workplace policy draft. Usually this person was appointed by the director to attend the STOP AIDS NOW! workshops, though some were the HIV and AIDS focal point person. Some CSOs also hired outside help to support in developing a policy, either to facilitate the participatory development or provide their inputs on drafts.

Getting senior management, directors, and the board involved in workplace policy development is critical, because they and the executive and financial committees are the people who have to approve a policy and are instrumental in putting it to implementation. For most CSOs getting the commitment of senior management was not a problem because they had been sensitized in the first STOP AIDS NOW! workshop for directors in June 2005, plus some senior managers also attended the STOP AIDS NOW! capacity building workshops. The directors or senior managers were also interviewed and so sensitized about the project in the baseline survey.

In AR1, 46% of the 406 staff interviewed said their organization has a (draft) workplace policy, and 66.5% reported that they were involved in the development of this workplace policy – which is a promising finding. Most of those involved contributed by commenting on the first draft: 51.6% by giving comments on the draft that was circulated; and 19.4% through review meetings and workshops on the draft. Others were more actively involved by taking part in workplace policy developing workshops (17.7%) or were responsible for the drafting of the policy (8.9%). As would be expected, management level staff was relatively much more involved (83%) than support staff (28%), with administrative staff (71.8%) and technical staff (69.7%) in the middle.

AR2, which covered 47 CSOs (out of 72) that had developed a (draft) workplace policy, showed that nearly all organizations developed the policy in a participatory manner, mostly by internal meetings to discuss opinions and needs of staff. Others constituted a drafting committee, with other staff commenting on the drafts in staff meetings, group discussions, and sensitization workshops. Some organizations arranged training programmes facilitated by outsiders, during which staff members were mobilized to come up with their views regarding the implication of the policy. These workshops were to enable the staff to know what they were required to do and address.
Results of AR2 showed that the number of CSOs with final and draft policies has increased, as have CSOs that have started to implement activities, even if limited. Of the 72 CSOs visited in AR2, 24 had a final workplace policy, 23 had a draft workplace policy, while 25 had no policy in place yet. Out of the 25 without a policy, 4 had started the process and 14 were definitely interested in starting. Of the 47 who either had a final or draft policy, 27 reported having activity plans in place. Looking at the 51 CSOs that were visited in AR1 and AR2, 26 made progress: 8 from no policy to a draft, 13 from draft to final, and 5 from none to final. 15 still did not have a policy, while 10 were still in draft form.

In AR3 there was purposeful sampling of 29 CSOs with a draft or final policy, so no comparison can be made based on the AR findings. However, STOP AIDS NOW! project reports show that a total of 50 CSOs now have a (draft) policy. From the 29 CSOs in AR3, 24 (82.8%) had a final policy, and 5 (17.2%) a draft policy. The majority (20) of the organizations developed their policies under STOP AIDS NOW! arrangement. Of the 29 organizations studied, 12 have incorporated their policies into their human resource policy and/or health policy, while 16 have their policies as a stand-alone policy. Nearly all interviewed staff in the CSOs (89.7%) are aware of their organization's workplace policy.

3.3.1 Issues of contention

Developing workplace policy in a participatory way will obviously lead to some discussions on what to include. Different levels of staff will have different needs and wishes, and managers have to deal with the financial implications. In AR1 and AR2 the following topics were hotly debated:

- What sanctions to put in place against staff discrimination – can people be dismissed on allegations of discrimination, and could PLHIV misuse this?
- Whether to provide condoms in the workplace for staff – especially controversial in FBOs because it goes against religious convictions, but also for some staff in secular CSOs referring to their moral convictions;
- Whether to promote VCT – and what then to offer when staff test HIV positive;
- Whether ART and treatment for opportunistic infections can be paid for by the CSO, and questions of eligibility to treatment, including whether family members should be included (organizations that already had a health scheme for staff had to discuss whether to add ART, whereas for organizations that did not it was more difficult to provide access);
- What care and support to provide for sick staff (paid leave, lighter work tasks, termination of contract);
- Providing a safe and healthy work environment, e.g. by providing first aid kits, use of detergents, gumboots for workers;
- Whether to make the HIV and AIDS workplace policy a stand alone policy versus incorporating it in human resource policy:

"... Then there was also another debate on whether the workplace policy should be put in the HR policy, or should be left as a stand alone policy. The fear was that if you included it in the HR policy, what would happen is that it would be ignored and not seen as a major policy. We decided we preferred to have it as a stand alone policy so that when it comes to raising funds for it, it is much easer that way." (focus group discussion, EASSI)

3.3.2 Basic elements contained in the workplace policy

All the organizations' workplace policies contained almost similar elements, which is not surprising since most were involved in the training by STOP AIDS NOW!, and their draft policies were reviewed and commented on by the STOP AIDS NOW! workplace policy review committee. Most included: promoting a non-discriminating environment, encouraging disclosure, raising awareness, providing education and prevention, care and support, facilitating access to treatment, and focusing on gender equality. Some included condom promotion and provision, and first aid kit provision.

3.4 Implementation of workplace policy activities

As would be expected, over the course of the project an increasing number of CSOs started implementing activities for staff related to HIV and AIDS. In AR2, 36 out of 47 CSOs with a (draft) workplace policy reported having started at least some activities; 3 reported full implementation. Main activities implemented were: awareness raising and sensitization of staff through routine discussions or special training (in all CSOs); preventative measures by provision of a First Aid kit and condoms; provision of information and education materials in an AIDS corner, through posters, leaflets, or a newsletter; access to VCT and/or ART services, paid for by the organization, health insurance, or by establishing referral systems linking to specific service providers. It was interesting to find that normally, in focus group discussions with staff, more activities would be mentioned than in the IDIs, pointing to the fact that workplace policy and its activities are noticeable among staff.

In AR3 all but one CSO had started implementing workplace policy activities, including the following: awareness raising (28) – through routine discussions (19), internal training for staff (11), or training by externals (6); provision of IEC materials displayed on notice boards (17) or in AIDS corners (12); VCT promotion (19); measures to reduce stigma and discrimination, for instance through punishment or suspension (15); addressing gender concerns (15); condoms for staff (18); access to ART (10), care and support for HIV positive staff (7), counselling (9); and guidelines for disclosure and confidentiality (10). Staff were generally aware of the activities and did participate in them – as will be discussed in more detail in later sections.

3.5 Effects of workplace policy activities

Although implementation of workplace policy had just begun, effects were already noticeable in AR2, as managers reported that the policy created greater HIV and AIDS awareness and had given staff confidence in job security. VCT uptake and use of condoms (if provided) has also increased, and decreased stigma and discrimination were noticeable. Results reported by staff in focus group discussions included increased awareness, increased uptake of HIV counselling and testing, increased staff openness to talk about HIV and AIDS, reduced stigma and discrimination, increased condom use, increased confidence of staff in job security even if HIV positive, and greater visibility of lead organizations.

In AR3, effects of the workplace policy activities were noticed by managers in 26 out of the 29 CSOs, and most staff were also aware of the effects, listed below:

- **Level of awareness raised regarding HIV and AIDS**
  75.9% of CSOs and 67.4% of staff report increased knowledge of HIV and AIDS.
- **Changed attitude towards PLHIV**
  55.1% of staff reported changed attitudes towards PLHIV (not necessarily in the workplace) because of the workplace policy.
- **More openness about HIV and AIDS**
  In 72.4% of CSOs and by 63.6% of staff, more openness was reported regarding discussion about HIV and AIDS as a result of the workplace policy.
- **Stigma reduction**
  In 62.1% of organizations HIV related stigma was reduced because of the workplace policy, although it was acknowledged that stigma remains a challenge.
- **Intention to disclose**
  Among staff, 46.6% said the workplace policy made them likely to disclose their HIV status if they found themselves to be positive, although 15.3% said they would have disclosed even before the workplace policy.
- **Staff disclosure of HIV positive status**
  Six organizations report that disclosure increased because of the workplace policy; 10.6% of staff know an HIV positive person in the organization – 64.0% of these were told personally by the HIV positive person.
- **VCT uptake increased**
  In 37.9% of CSOs increased VCT was reported; while 19.9% of staff said that the workplace policy had motivated them to go for VCT, others had already gone on their own initiative, had been tested when preparing for marriage, or had received routine testing when in hospital or during pregnancy.

- **Behavioural change**
  39.0% of staff said their behaviour had changed because of the workplace policy; change related mainly to safer sexual behaviour, including being more faithful to one partner and using condoms outside of marriage or with casual partners.
- **Increased use of condoms**
  About one-third (34.5%) of CSOs report increasing numbers of staff taking condoms provided by the organization.
- **Workplace more gender sensitive**
  Nine CSOs report a more gender friendly workplace; only 6.8% of staff felt gender relationships have changed, though this may mean that many workplaces were already gender friendly.
- **Increased involvement of family members and friends**
  In 34.5% of CSOs, family are reported to be more involved because of the workplace policy; almost half of staff (46.2%) reported discussing the workplace policy and AIDS issues with family and friends outside the workplace.
- **Increased linking and learning**
  69.0% of organizations reported increased linking with and learning from other organizations; 62.1% linked with other STOP AIDS NOW! partners, 55.2% with various service organizations generally, 65.5% with organizations for IEC, 44.8% for condoms, and 37.9% for training.

3.6 Reflecting on the applied research

3.6.1 CSOs using AR recommendations

As was envisioned through the AR, CSOs learned from one another; recommendations that were brought up by the AR were found to have been consequently taken up by some organizations when they were visited during data collection in the subsequent AR phase. For example, recommendations to CSOs arising from AR1 or AR2 that were implemented to a large extent by participating CSOs by AR3 included the following:

- Having an AIDS focal point person to oversee the implementation of the workplace policy activities.
- Implementing workplace policy related activities that do not cost money, such as discussions and awareness raising.
- Discussing feasible ways to provide access to ART.
- Continuing to write proposals for funding to other donors to broaden implementation, instead of waiting for STOP AIDS NOW! donor funds to begin implementation.
- Having routine discussions on HIV and AIDS in the workplace, for instance during routine staff meetings.
- Linking up with (free) information, counselling, training, and service provision organizations.
- Linking with and learning from STOP AIDS NOW! partner organizations through promising practises in AR reports, by networking during STOP AIDS NOW! workshops, and through exchange visits.

3.6.2 AR visits as reminder

Through the AR team visits and questionnaires, CSOs were reminded of the workplace policy project and its important elements. For instance, AR3 also conducted an evaluation of the Good Donorship Guidelines and Budgetting Tool, and the recommendation of CSOs was to provide more information on these tools, when through evaluation they realized that they did not know enough.

3.6.3 AR limitations

The AR has not been as effective as it could have been. In AR3 it was found that although managers in 23 CSOs had seen and read through the AR reports, only 30% reported to have fully used them. Obviously, dissemination has not been optimal. However, the project coordinator and local project group have used AR recommendations to CSOs by including them in training, so messages have come across, which may explain why so many have followed the promising practices of their peers. Moreover, the AR team has given some oral presentations with PowerPoint slides on preliminary AR findings during various training for CSOs.

Less than optimal dissemination and use of findings can partly be explained by late reports and a limited number of hardcopies. Because it took so much time between data collection and the reports – between 6 to 10 months – CSOs may have already lost interest in the findings, possibly thinking that they are no longer relevant because they have since progressed. Although reports were made available online and were downloadable, most CSOs did not access the reports in that way. They preferred hardcopies. The factsheets prepared for each phase were not accessed at all.

A limitation for analysis was that the same CSOs were not always involved in all AR phases (see Annex 1). Because of limitations on time, finances, and safety, not all CSOs could be visited in each phase. Especially in AR3, there was a bias towards CSOs with a (draft) policy – to document effects – thus we cannot generalize findings to all 76 partner CSOs.

4

Focusing on STOP AIDS NOW! Project structure and approach

In this chapter we focus on the Uganda STOP AIDS NOW! project structure, STOP AIDS NOW! documents, M&E system, and its approach. The structure goes down to the HIV and AIDS focal point persons in CSOs. Important approaches in the STOP AIDS NOW! project are capacity building, involvement of PLHIV, and incorporating sustainability. We evaluate whether the structure and approach was supportive of the project objectives. Information for this chapter is derived from review of the AR1, AR2 and AR3 reports, and from the data collected for this phase, as explained in the Chapter 2.

4.1 STOP AIDS NOW! project structure

The STOP AIDS NOW! Uganda project structure included the local project coordinator's office, based in the host organization ACORD, the local project group, and the three regional lead organisations, which were to provide training, supervision, and guidance in workplace policy development and implementation in the individual CSOs. The project office also housed the M&E officer (since January 2008) and the programme manager (since July 2008). The project received advice and technical support from a Dutch project coordinator, and programme officers of the STOP AIDS NOW! donors supported individual partner CSOs.

The project structure was evaluated by the Ugandan stakeholders, including the local project group chair, present and former local project group members, CSO managers and focal point persons, focal point persons of lead organisations, and the former project coordinator(who left in October 2008). Data collection was mainly through interviews; and in the one day workshop the local project group and lead organisations reported their respective activities, did a SWOT analysis of their functioning, identified challenges, and gave recommendations for improved operations. Overall, stakeholders expressed that they valued the STOP AIDS NOW! structure because there is local ownership through the project coordinator, local project group, host organization, and lead organisations. The support by the Dutch project coordinator was also valued.

4.1.1 SWOT analysis of local project group

We will start with an evaluation by the local project group of their work and compare it with their terms of reference – summarized in Table 1 – after which opinions of other stakeholders will be presented.

It seems that local project group activities greatly covered the responsibilities as formulated in the terms of reference. However, the local project group members saw some challenges in executing their responsibilities, including the following:

- It proved difficult to convince some partnering organizations, especially small organizations which feared the costs of developing and implementing workplace policies.
- The time available for the STOP AIDS NOW! project was too limited – only 3 years. workplace policy is a new issue for most CSOs and it took time to get it established.
- The local project group had budgetary constraints; they had wanted to support CSOs more by conducting exchange visits to organizations.

During the workshop, local project group members made an analysis of their strengths and weaknesses, and considered the opportunities and threats, as summarized in Table 2.

Identified *strengths* of the local project group related to the strong capacity among the members concerning HIV and AIDS, the experience of HIV mainstreaming, and the fact that the local project group is represented by organizations with different expertise as their core business. A further advantage is that they have wide networks. The local project group meets regularly and there is good coordination, and they are happy to have a strong host organization (ACORD) committed to HIV and AIDS and the STOP AIDS NOW! cause. It was considered a strong point that over the three years of the project, the membership of CSOs in the local project group has been stable.

Weaknesses identified included that not all members were regular in their participation of meetings, some giving the local project group less priority, and sometimes time keeping was poor. It was recognized that the representatives were not always consistent for all local project group organizations, and further, not all organizations were consistently supporting the STOP AIDS NOW! coordination office – for instance, they did not respond to mails in time and did not give feedback to communication by the project coordinator. Currently, the local project group is a bit static with the same 7 members. They also feel they should advocate the project more. local project group members feel there was limited inter-phase communication between the local project group and implementing partners beyond the project coordination unit. However, the local project group chair, in a separate interview (he could not participate in the workshop), did express the feeling that the local project group is like a board which should be in the background, while the secretariat

Table 1: Main responsibilities of local project group

From terms of reference	Self reported activities
• Monitor the project implementation process • Offer support in developing new proposals and periodical review of the country project proposal that includes a working document with an action plan • Contribute to knowledge management, linking and learning processes • Review reports made by the local Project Coordinator • Organize quarterly meetings to review the progress of the project • Recruit and appraise the coordinator with the hosting organization • Accountability (report) for coordinator and hosting organization • Develop regulations for partner organizations and project group	• Workplace policy (draft) reviews • Provided IEC materials for prevention • Set up referrals for counselling, testing, and treatment (see linking and learning) • Capacity building of organizations (see capacity building) • Fundraising – proposal for Civil Society Funds, which were awarded • Provision of technical advice on workplace policy development • Encourage implementation of workplace policy • Encourage exchange learning visits • Awareness raising

Table 2: SWOT analysis local project group

Strengths	Weaknesses
• Diverse skills and experience • Wide existing networks of members • Good host organization • Regular meetings • Balanced membership of CSOs	• Poor attendance in meetings • Inconsistent representation of staff • Project Coordinator not given enough support • Stasis because of consistent membership • Poor links with partner CSOs • Insufficient marketing of project • No (more) representation of key stakeholder the FBOs
Opportunities	**Threats**
• Political will and support • Uganda document on workplace policy – still to be implemented • HIV recognized as a problem • Free support available • Presence of other donors	• Economic crisis • Dependant on donors • Changed dynamics in organizations' structuring • Staff turnover within organizations

does the work. The former project coordinator, for his part, thought the local project group could have given more direction to the project coordinator office and the project.

There are many *opportunities* for the local project group to succeed in supporting the development of workplace policies. There is a favourable policy environment in Uganda for the STOP AIDS NOW! project and related work: Uganda Government has a document on workplace policy (that still needs to be implemented), HIV is recognized as a priority problem in Uganda, and there are free services available – which make implementing a workplace policy for organizations less costly. Further identified opportunities were also the Civil Society Fund that could be applied to, and that other donors exist which may be approached for funding. The fact that a large group of 76 CSOs were involved and trained constitutes a critical mass for advocacy purposes.

A threat to the programme was considered the dependency of CSOs on STOP AIDS NOW! donors, especially now we all face the global financial crisis. Other donors may therefore not subscribe to the Good Donorship Guidelines – i.e. the commitment to financially supporting workplace policies. A threat is also the stance of FBOs on condoms, which is one of the prevention strategies advocated through most workplace policies. A threat to the local project group is the non-involvement of FBOs in it – the one FBO local project group member opted out, resulting in no more FBO representation in the local project group. A further threat is also that there is little IEC available on workplace policy, although a lot of IEC on HIV and AIDS is available in Uganda. An identified risk is also individual CSO dynamics – which may entail restructuring, change of goals and focus, etc. and especially staff turnover within member organizations affecting local project group performance and institutional memory/continuity.

4.1.2 SWOT analysis of lead organizations

The main responsibilities of the lead organizations – TPO, Health Need Uganda, and FURA – as formulated in their Terms of Reference relate to:

- Supporting partner CSOs in developing and implementing a workplace policy
- Forwarding the workplace policies developed by CSOs to the STOP AIDS NOW! project office
- Helping in organizing project activities within the region, as planned by the coordination office (trainings, venue, resource persons, PLHIVs, etc)
- Being the liaison between CSOs and the project office
- Providing information to both sides; and
- Making summary reports of the activities in the region.

They are supposed to do this by regular visits to organizations during support-supervision, meetings with participating organizations (formal and informal), and inter-organization exchange visits, and they should assign one staff to do the workplace policy work – the focal point person.

The lead organisations' focal point persons reported that they could perform most activities listed in their terms of reference. They advised the partner organizations in their region and gave training on workplace policy development and implementation. They also advised on external mainstreaming for organizations which have core businesses other

Table 3: SWOT analysis by lead organizations

Strengths	Weaknesses
• Have capacity • Have skills for guiding workplace policy development and implementation • Have resources and staff • Commitment to guide other CSOs • Have strong social networks and linkages • Have workplace policy • Credible organizations	• Focal point person have to divide time between STOP AIDS NOW! and other duties • Delay in submission of reports
Opportunities	**Threats**
• Known by most donors • HIV and AIDS mainstreaming is recognized as important issue • Existence of the CSF	• Vast area coverage – heavy workload • No availability of new IEC materials • Staff turnover – committed persons in the organization may leave • Poor donor response • Inadequate funds, especially for supervision

than HIV and AIDS. However, they also reported some weaknesses and threats to their operations, as summarized in Table 3.

Strengths of the lead organisations relate to their credibility and wide social networks, to their experience with workplace policy, and to the fact that they have enough staff to do the work. The main reported *weakness* is that they do not have time enough to do the work and write reports because of other duties. In TPO and Health Need Uganda, they have someone seconded to work with the focal point person, while in FURA the focal point person relies on possible volunteers to work with her. The former project coordinator commented that not all lead organisation focal point persons have enough technical ability, also because of staff turnover; supporting this argument is the fact that lead organisation focal point persons said they would like to travel with the project coordinator when he is in their area, because it would cut costs and they could learn on the job.

The lead organisations consider as *opportunities* for successful operations the fact that there is a conducive atmosphere in Uganda, where HIV mainstreaming is acknowledged and there is money available; while the dependence on (not forthcoming) donor funding, and the subsequent lacking of funds for activities, is seen as the main *threat*.

4.1.3 CSOs' opinions on support structure

In AR3, in which 29 CSOs were involved, nearly all (93.1%) reported having received technical support from within the STOP AIDS NOW! structure; and when probed for where specifically the support came from, 26 (96.3%) reported support from the project coordinator, 17 (58.6%) from the lead organisation, 5 (17.2%) from the local project group, and 3 (10.3%) from the Dutch programme officer. Six CSOs (20.7%) reported spontaneously to have received support from peer CSOs participating in the STOP AIDS NOW! project.

CSOs reported that support visits by the project coordinator helped in the formulation of their workplace policy, and he guided them on how to develop it. Organizations continued to consult him on whether they were on the right track in the development process. The supervisory role of the project coordinator was also important when

Table 4: Expressed need for support from STOP AIDS NOW! structure by CSOs in the 3 AR phases

Recommendation to specific level	AR1	AR2	AR3
Project coordinator, local project group, lead organisation	• Facilitate access to materials on development of workplace policy, including Good Donorship Guidelines and Budgeting Tool • Organize capacity building in the regions which also includes managers, specifically on budgeting, stigma, and sexuality	• Continue with capacity building workshops and invite more staff per organization to accommodate staff turnover	• More education on Good Donorship Guidelines and Budgeting Tool • Support visits by project coordinator and lead organisation, especially for implementation of workplace policy, workshops at organizational level, and assistance with self assessment at the organizational level
Dutch STOP AIDS NOW! donors	• Earmark money for workplace policy, quickly screen budgets, and quick release of money	• Provide technical support to CSOs on workplace policy • Timely funding for workplace policy activities	• Screen budgets and release funds quickly • Lobby with other donors for funding

organizations were doing the budgeting. Those organizations that said they benefitted from the lead organisations mainly reported that they were given support by the lead organisation focal point person who came in person to share with organizations and guide them on how to develop their workplace policy. Additionally, some lead organisations were reported to help with providing condoms. Several organizations most valued the STOP AIDS NOW! capacity building workshops that guided them in the development and implementation of workplace policy, though sharing information and reminders about how to develop and implement their workplace policy is what some organizations considered most useful. Obviously, the local project group is less visible with the partner CSOs, with only 5 reporting having received support from them, and even less support was received from Dutch programme officers. Although support was appreciated, in all three AR phases, CSOs recommended more and specific assistance, as summarized in Table 4.

In all phases CSOs were eager to receive more capacity building assistance with workplace policy development and implementation, and also with the specific STOP AIDS NOW! tools (Good Donorship Guidelines and What's it likely to cost?). CSOs were also advising the training of more than one staff member because of usual high staff turnover in CSOs. In fact, to prevent this loss of capacity, in some CSOs staff returning from STOP AIDS NOW! workshops were required in turn to train peer staff. The main support from the Dutch STOP AIDS NOW! donors which they asked for was financial, not technical. This is a promising finding, because obviously the local STOP AIDS NOW! structure gave sufficient technical support (although it could always be more).

4.1.4 Evaluation of project structure by local project group

During the local project group workshop, participants evaluated the STOP AIDS NOW! structure and identified challenges, but also gave recommendations

Table 5: Evaluation by local project group of STOP AIDS NOW! structure

Concerns	Proposals
Technical and budgetary support by STOP AIDS NOW! donors sometimes weak. For program officers of the donor agencies, workplace policy may not have been a priority (which in a way is understandable because programme officers are overwhelmed with (other) concerns)	Ensure that the Dutch STOP AIDS NOW! partners have a uniform way of implementing support for workplace policy, following the Good Donorship Guidelines and What's it likely to cost?
Poor communication between project coordinator(Uganda) and programme officers of the Dutch donors – so there were delays in the approval of budgets for workplace policy and release of funds	Find a way of linking the Dutch program officers with the project coordinator office – inform the (new) programme officers about project structure and ways of screening workplace policy and budgets of participating organizations
Link between local project group and CSOs too weak – some organizations do not know about existence of terms of reference of local project group	Consider rotating local project group membership – have a core group and rotate some of the seats to have representation from regional level CSOs; have local project group visit CSOs
Constitution of local project group and participating CSOs was too influenced by the Dutch donors – not locally initiated, poor representation of CSOs in local project group and in project (out of 150 CSOs who are believed to be supported by one of the Dutch donors, only 76 participated)	Need to clarify communication lines and Terms of Reference for stakeholders at all levels
Not always clear to local project group whom the project coordinator is working for and with, and who evaluates the project coordinator– the host organization or STOP AIDS NOW! project; the project coordinator does not seem to be independent	Make clear guidelines for the position of project coordinator; if the new independent project relocates it will bring a new identity to the project coordinator and host organization

for addressing their concerns, which are put together in Table 5. It has to be noted that these are the views of the local project group, and that other stakeholders – e.g. Dutch programme officers, Dutch project coordinator, and CSOs – may have other views on the same issue. The local project group proposals will be considered when giving the recommendations in Chapter 6.

4.2 Supporting STOP AIDS NOW! documents

The two supporting STOP AIDS NOW! documents are the guidelines 'Good Donorship in a time of AIDS' and the budgeting tool 'What's it likely to cost', which provide direction on how to develop a workplace policy and an accompanying budget respectively, as well as what support can be expected from the STOP AIDS NOW! donor agencies.[5] The Good Donorship Guidelines was developed before the project in Uganda really started, while the budgeting tool was written over the course of the project when it appeared that budgeting was a problem for many organizations: not knowing what could be included and how to make a budget. The documents were distributed by the project coordinator to the various organizations, in both hard and softcopy. CSOs can also access the documents from the STOP AIDS NOW! website. The documents were reportedly also explained in workshops to directors, managers, and focal point persons, and during support visits by the project coordinator and lead organisations.

[5] The documents can be downloaded from the STOP AIDS NOW! website – 'professionals': **www.stopaidsnow.org**

Overall, CSOs are aware of the Good Donorship Guidelines, but less of the budgeting tool, and not all have read the whole documents. In AR2, interviews with managers showed that 11 out of 38 (28.9%) had not seen or heard about the Good Donorship Guidelines, while 27 (71.1%) were aware of the Good Donorship Guidelines – with 23 reportedly having used the Good Donorship Guidelines for development of policies or for finalising the workplace policy (the other 4 were aware but had not read them). In AR3, out of 29 respondents, 24 (82.8%) knew about the Good Donorship Guidelines document – though only 7 (29.2%) had read the whole document, while 17 (70.8%) had read part of it. Less than half of the respondents, 11 out of 27 (40.7%), had seen the budgeting tool. Evaluating the usefulness of these documents, 15 (62.5%) organizations considered the Good Donorship Guidelines very useful, and 9 (37.5%) somewhat useful. Concerning the budgeting tool, of those 11 who had seen it, 8 (72.7%) found it very useful, while the other 3 (27.3%) found it somewhat useful. They reported that the guidelines were useful in budget development and in the planning processes, and that they helped them to make budgets that were realistic and not exaggerated. The formula provided was important in helping them to make calculations for the budget, and it also provided them with a reporting format. Furthermore, the Good Donorship Guidelines provided organizations with insight into the permitted activities, and in how to develop a work plan. One CSO (CEFORD) even used the STOP AIDS NOW! tools for making other budgets that are not related to the STOP AIDS NOW! project.

The commitment of donors, spelled out in the Good Donorship Guidelines, to pay an amount up to 4% of staff salaries towards the workplace policy was the commitment remembered by most, but was also the commitment most organizations had problems with.

Table 6: Concerns and suggestions of local project group for STOP AIDS NOW! tools

Concerns	Suggestions
• Not all partners understand the tools completely and the documents are long to read • Not enough sense of ownership: even lead organisations reported they had problems internalizing the Good Donorship Guidelines, and that it took them quite some time (let alone the training they are supposed to do about it to CSOs in their region)	• Need for STOP AIDS NOW! to see how the tools can be locally owned and made use of; this will enhance ownership • Repackage the Good Donorship Guidelines and budgeting tool into simpler formats for use by organizations, e.g. CDs, leaflets, posters, etc.
• Very short time frame for adequate selling of the tools to CSOs and to market tools to other donors of the CSOs	
• Some organizations have not used them	

They said that if the salary of staff is low then the promised 4% is a very small amount and inadequate to cover many activities. It is possible that the donors had calculated the 4% with experience from another country where staff salaries are usually higher.

In the local project group workshop, participants said that the Good Donorship Guidelines and budgeting tool were appreciated and useful, and have been disseminated to the organizations by project coordinator and lead organisations. In Table 6 are presented the concerns of the local project group about the support documents, and the suggestions they made for improvement of the tools and dissemination – these will be of importance for the recommendations of this report.

The concerns of the local project group considering the short time for using the tools is understood – but fortunately, because of the Civil Society Basket Funding, there is still time to promote the tools to other donors.

4.3 STOP AIDS NOW! project database

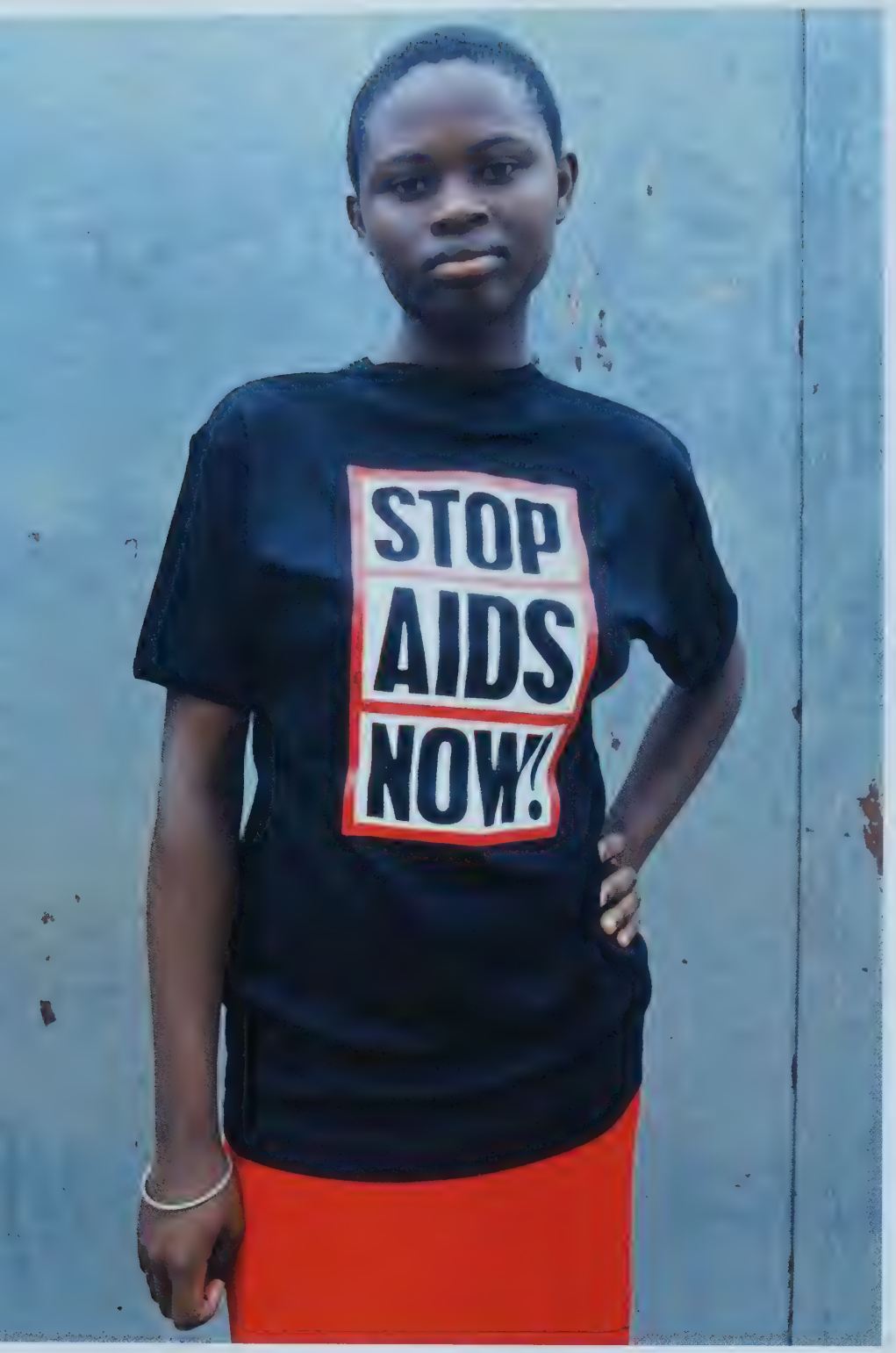
The STOP AIDS NOW! project information database serves as a tool for project management and for CSOs to monitor activities and progress. Every quarter CSOs should digitally feed information into their CSO page of the project information database. In AR3, the majority of CSOs – 25 out of 27 (92.6%) – reported accessing the STOP AIDS NOW! information database. All respondents indicated it was the focal point person who filled in the information database as he/she was mandated to do so. Most organizations found the information database to be user friendly, stating that it helps organizations to know what progress they have made by tracking what has been implemented and how far they have gone in all activities, and also said that the questions in the information database act as checks of what is expected of organizations.
Though it was said to be user friendly, some reported that there were quarters when the CSO had not done anything and therefore there was nothing to report; yet nowhere in the Information Database was there

Table 7: Local project group evaluation of project database, concerns and solutions

Concerns	Solutions
• The information database has been used but some CSOs feel it was imposed from outside • Partners do not see the benefit for themselves and it is extra work for them • Some of the same data have to be entered every three months	• Involve the recipients in the design stage (or now: in revision of the database) • Try to make it more attractive – for instance, on home page give a weekly information update, including links and downloadable reports • Give more feedback to partner organizations about what they and other organizations are reporting in the information database
• There has been a delayed information flow • Training on the database was not mainstreamed in the organization – so if staff leaves, the knowledge departs as well • Even the local project group has not done much with the database	• POs should receive feedback

Table 8: Activities of focal point person

- Information dissemination
- Establish and maintain the HIV and AIDS corner and the first aid kit
- Organize HIV talks for staff
- Provision of condoms
- Guide staff where to access HIV related services: VCT, ART
- Represent organizations in meetings regarding HIV and AIDS at the workplace
- Visit sick staff
- Organize internal and external workplace policy events, for instance VCT days



a way to indicate this. One of the main problems for some was their computer network problems. Others reported that the information database has too many information fields that one has to keep filling; they recommended deleting some sections (not specified which).

In the information database audit report for the period April to December 2008, a challenge was identified in that the project coordinator relies for his quarterly reporting on CSOs having completed the information database, though not all do fill it in on time, for various reasons: they are too busy, not motivated, or are delayed because of poor Internet access. The M&E officer resolved the issue by the project coordinator and lead organisations collecting a hardcopy of the information when visiting the CSOs, and then completing it in their own offices. Table 7 provides the local project group evaluation of the information database, presenting challenges and solutions to the problems.

4.4 HIV focal point persons

The HIV and AIDS focal point persons in organizations are pivotal persons in the STOP AIDS NOW! structure. They are the link between the CSO, lead organisations, and the STOP AIDS NOW! project office. To appoint such a person was a recommendation by the STOP AIDS NOW! project, based on literature on workplace policy development. He or she is a staff member, appointed by management to coordinate workplace policy activities, usually on a part-time basis. focal point persons are mandated to execute the workplace policy programme. They are and have been the initiators, mobilizers, and coordinators of workplace policy issues within the organization. Their activities normally include those in Table 8.

In AR2, the appointment and level of commitment of the HIV focal point persons were found to have played an important role in facilitating the implementation of the workplace policy. Often, the focal point person attended seminars and then shared information with the rest of the staff. STOP AIDS NOW! provides IEC materials through them to facilitate exposure among staff to HIV and AIDS issues in the workplace. The local project group members interviewed in AR2 commented on the importance of choosing a qualified focal point person:

> "There has to be a focal point person at an office to coordinate activities. Sometimes they pick somebody that should be in charge of HIV and AIDS yet sometimes this person is not qualified in mainstreaming. But if they bring on board someone who is competent, then in most cases activities run."

Nearly all organizations which have started workplace policy implementation have an focal point person – all but one of the 29 CSOs studied in AR3 have an focal point person; 12 are male, 16 female. Such a person is well known by the staff: in AR3, 209 (88.6%) of all 236 staff knew who the focal point person was, and 188 (79.7%) claimed to know the focal point person's activities.

All focal point persons have other positions, thus being the HIV focal point person is an added responsibility. Their other positions range from administration, finance, human resources, communication, to programme and logistic officers, and only one is the HIV and AIDS programme officer. A minority (2 out of 19 who answered) work as the focal point person almost full time, 10 work about half time, 6 about one day a week, and 1 less than one day a week. Some organizations pointed out that staff turnover, especially for focal point persons, was one reason for delayed development of their workplace policy.

In 28 CSOs in AR3, we asked about the training focal point persons received in workplace policy. Twenty-four (85.7%) focal point persons had received STOP AIDS NOW! training in workplace policy, and only 4 (14.3%) had not. Most of the focal point persons attended more than one STOP AIDS NOW! training: 50% attended the training on the STOP AIDS NOW! information database, 46.4% on workplace policy development, 32.1% on the 12 box model (for CSO self assessment), and 10.7% on peer education. However, most likely there was underreporting of the training attended, because interview respondents (managers) may not have known – not all focal point persons in CSOs were asked personally.

In AR2 focal point persons generally said that they valued the training received from STOP AIDS NOW!, as the following quotes illustrate.

"They helped me spearhead the process of workplace policy within my organization. ... You know, the development of this policy, I was guided and during budgeting, the Good Donorship Guidelines helped me to make a modest budget." (AMFIU)

"My last training was very useful because it helped me to provide information that STOP AIDS NOW! needs about our workplace policy and also to access what other SAN partners are doing regarding workplace policy. We learnt how to access the database and now I am able to access other organizations' progress on the net." (CEFORD)

"I have shared with colleagues from other organizations on how to develop workplace policy and also come up with realistic commitment in the policy." (JIDECO)

Focal point persons of lead organisations are special, because they are supposed to be trainers of other focal point persons in CSOs in their region. All focal point persons from the lead organisations expressed that they found the peer education training extremely useful for it enabled them to better talk about sensitive issues with peers; peers being everyone you feel equal to in one way or another, whether it be colleagues, or people of the same sex, same job, same age. Because of all the training they received, the lead organisation focal point persons felt somehow facilitated to train others, but were not yet completely confident.

4.4.1 Challenges facing focal point persons

Focal point persons expressed the feeling that they faced several challenges in their work, as pointed out below, which should be considered in future, including possible revision of the terms of reference.

Balancing organizational work with the STOP AIDS NOW! focal point person work:

"Focal point person work is an additional task I have to do but at the same time I work as an M&E officer I must confess that the type of work I am doing sometimes makes me too busy to do workplace policy work." (LABE)

Change of focal point person due to staff changing jobs or roles:

"Like I told you when Manjit left this organization, she left with everything and much as I was here with her for a full month before her departure, she did not mind to brief me about the progress of our workplace policy and that is partly why we have not done much because we do not have a written down policy in place and I have not looked through the softcopies she left behind." (Hospice Africa)

The structure and geographical areas of operation may complicate coordination and communication:

"In CEFORD, the biggest challenge is that we have three different offices, so most of the time the information or communication comes first to Arua head office. So I have to ensure that I get copies to send to field officers for others to access, which is not easy and sometimes costly in terms of time and finance." (CEFORD)

4.5 Capacity building

Capacity building at various levels, through workshops and support visits, is an important strategy used to build knowledge and get stakeholders motivated and involved.

4.5.1 Capacity building of CSOs by the STOP AIDS NOW! project

This started with the sensitization of directors and senior managers in a workshop in June 2005. The workshop objectives were to create harmony and alignment among STOP AIDS NOW! partners for the project, to sensitize directors about the need to address HIV and AIDS in their workplace, and for them to learn about the basic ingredients of how to formulate a workplace policy. Then several two day workshops on peer education and workplace policy development took place in October 2005 and the first months of 2006, in the three regions. Participants were mainly focal point persons but also managers and some directors attended. In 2007, focal point persons were trained in the 12 box model tool for organizational self assessment of HIV and gender sensitive workplaces. In 2008, focal point persons and other representatives received training on how to fill in and use the STOP AIDS NOW! information database.

4.5.2 Capacity building within organizations and its effects

Within CSOs capacity building of staff took place, and as with CSO heads, awareness raising about HIV and AIDS and sensitization of staff was an important first training step to get them motivated for a workplace policy. During AR1, 47.8% of staff representing 42 CSOs (out of 406 staff interviewed in 60 CSOs) reported that their organizations had organized IEC sessions to build capacity of staff – 83.2% of those who knew also participated in the training sessions. According to staff, focus was on modes of transmission, fighting stigma and discrimination, condom use, HIV testing, and use of ART. That the training content was taken on board is demonstrated by the fact that 68% of those who attended IEC sessions said that it made them change their behaviour (AR1). That some staff did not participate in training does not mean they did not receive any information, because 54.4% of trained staff said that they shared the information they gained with workmates.

In AR2 it was found that in all the 36 CSOs which started implementing their workplace policy (out of 72 studied), sensitization of staff took place. Awareness raising and sensitization of staff concerning HIV prevention and other issues related to HIV and AIDS was done in several ways: through regular discussion among staff, through seminars and training, peer education, sharing of information and IEC materials, or hanging posters on the notice boards depicting preventive and non-discrimination messages.

"We need to repeat the messages and refresh people's minds on HIV and AIDS. We do this through bi-monthly meetings." (Africa 2000)

"There is creation of awareness within the workplace and community through the foundation course each morning. We have dedicated Friday afternoons to group discussions for issues to do with AIDS. If we are few we show a film and watch that." (FURA)

In AR3 all but one of the 29 CSOs organized awareness raising activities; 74% of staff reported knowing about activities, the majority (84%) of which also participated in them. In 11 out of 28 CSOs managers reported organizing specific training, either internally organized (11) or given by external trainers (6). From the staff survey we see that 123 (52.2%) participated in these training activities. The training subjects that were dealt with most were:

1 Signs, symptoms, and transmission of HIV and AIDS
2 Developing a workplace policy
3 Peer education
4 The effect of HIV and AIDS on beneficiaries of programmes, such as for adult literacy and fishermen; and
5 The 12 box model assessment. Training also covered positive living and rights of PLHIV, the STOP AIDS NOW! information database, counselling, and stigma and discrimination. Concerning IEC materials, 76% of

staff reported such materials being provided in the office, either on the notice board, in the AIDS corner, or in other places; nearly all of those who reported IEC materials (96%) said they looked at them.

In AR3, managers felt that a lot of awareness on HIV and AIDS among staff had been created through workplace policy related activities. Awareness is related to knowledge of HIV and AIDS 'basics', but also of the workplace policy, the importance of VCT and disclosure, and of the proper attitude towards PLHIV, i.e. not stigmatizing and discriminating against them.

"On awareness, it has gone up. And then there is a lot of openness among staff. Right now there are those who are willing to test. That is very good. Some might even lie that they have done it and yet they have not. There is more awareness." (Health Need)

More than two-thirds of staff (67.4%) in the AR3 survey reported increased knowledge about HIV and AIDS because of workplace policy activities. The most important issues which the 159 reporting staff members have learned are:

1 How HIV can spread and how to prevent it (49.4%)
2 Not stigmatizing and discriminating against people with HIV and AIDS (28.2%); and
3 The importance of a workplace policy (19.4%).

Almost half of the staff (46.2%) felt they now have enough knowledge about HIV and AIDS.

As a result of this raised knowledge and awareness, staff and managers report more open discussions on HIV and AIDS in the workplace, improved attitudes towards PLHIV, behavioural changes (for example, safe sexual behaviour), and more motivation to go for VCT.

4.5.3 Needs for capacity building

Although a lot of capacity has been built already, stakeholders at various levels said they still needed more capacity. The local project group chairman, the lead organisation focal point person, two CSOs, and staff expressed their views on specific issues they would like to be given training on or learn more about, outlined below.

4.5.3.1 Training of CSOs by STOP AIDS NOW!

CSOs in AR3 expressed that they would like more training on Good Donorship Guidelines and budgeting tool. EASSI would like to have training in counselling skills for an internal counsellor. The local project group chair gave his views on the topics he thinks CSOs should receive training on, given by STOP AIDS NOW!

- *Refresher training* for executives and focal point persons on awareness raising and sensitization, because of high turnover of staff. workplace policy needs the commitment of a skilled focal point person and of the director and senior managers.
- Training on *external mainstreaming* of HIV and AIDS, especially for the many organizations that are not in HIV work (some promising examples are provided in 5.3 of this report).
- *Special training for FBOs* to address the challenges of certain values that are barriers to workplace policy; denying HIV as a problem for staff, for instance.
- Training on how to *build on informal responses* to HIV and AIDS, including awareness raising, VCT, treatment, and care of HIV positive staff. Some CSOs do not want to commit themselves, but are actually doing a lot already.

4.5.3.2 Staff training needs

The training needs of staff in AR1 and AR3 were rather similar. In AR3, 112 staff – who reported needing more knowledge – had sometimes multiple information needs:

- 29.5% wanted to know more about *treatment with ART*, including side effects
- 18.8% still needed more *general information on HIV and AIDS*
- 14.3% wanted to know about *mother-to-child HIV transmission*
- 12.5% about *protection from HIV infection;* and
- Another 12.5% about *discordant couples.*

It was striking that compared to the answers in AR1, very few staff mentioned that they needed more information on how to *fight stigma and discrimination* – just 7.1% compared with 76.2% in AR1.

4.6 Involvement of PLHIV

One of the global principles in addressing HIV and AIDS is Greater Involvement of PLHIV (GIPA) – therefore one of the approaches in the STOP AIDS NOW! project was to involve them. PLHIV have featured and are involved in the project in different ways, and at different levels, either:

1 *Passively* as motivation for managers to develop a workplace policy; or
2 In an *active role,* member of the local project group, facilitating during workshops, engaging in advocacy to make staff aware of HIV and AIDS, and especially on the importance of addressing stigma and discrimination, and working on the development of a workplace policy.

4.6.1 PLHIV as (passive) motivation to address HIV and AIDS in the workplace

Having (had) staff living with HIV, or who had died, motivated organizations for workplace policy in different ways. Sometimes management said they were not happy with the ad hoc way in which they support HIV positive staff, and wished for more guidelines for structured responses. Furthermore, seeing fellow staff with HIV motivated staff to take HIV seriously, and brought the development of and participation in workplace policy forward.

In AR1 it was recorded that six organizations reported being directly affected by HIV, either by having (openly) HIV positive staff member(s) or a staff member who had died of AIDS. However, most organizations were *indirectly* affected because staff had to take time off for care and burials. Some organizations help sick and affected staff only in an ad hoc manner: FAPAD said there was no fixed amount given to employees who lose relatives, but it depends on the organization's financial ability at the time. Staff members out of good will may also contribute something. Having seen co-workers die of AIDS was particularly motivating for management and staff to address HIV and AIDS in the workplace, as the following cases show:

Workers in the focus group discussions in one of the CSOs explained that the two staff members who died of AIDS were experienced staff and their sickness and death affected the organization, when burial costs and death gratuity was paid by the organization (three months pay). The sick persons were only replaced after they had died – so the work was on hold while they were sick.

Another CSO who had HIV positive staff and who also lost staff to AIDS said they feel that as an FBO they have to help the employees financially and give counselling, but also have to help the family of the employee who died financially and with emotional support, attending burials, and helping even after the burial. They reported to have had problems financing all these expenses, because the welfare fund they drew from was too limited.

Seventy-one per cent of staff in AR1 said they had been personally affected by HIV and AIDS, and 57.1% felt there is an affect of HIV on the workplace. So for them, PLHIV are indirectly a motivation for the workplace policy, because a workplace policy could alleviate some of the negative effects of HIV on them personally. Tables 9 and 10 summarize how staff said they were personally affected by HIV and AIDS, and how it affects their performance at work.

4.6.2 Active involvement of PLHIV

PLHIV have been involved at various levels and ways in the STOP AIDS NOW! project, and various actors pursued their participation.

PLHIV at project level

The local project group requested that NAFOPHANU, a network of PLHIV, become a member of the local project group, even though they are not a partner to one of the STOP AIDS NOW! donors. They were considered to be best placed to advise on issues related the needs and rights of PLHIV in the workplace, and for stigma and discrimination reduction.
They actively participated during the launch of the STOP AIDS NOW! project in October 2005, and during STOP AIDS NOW! training PLHIV are usually asked to share their experiences and facilitate sessions.
In addition, one male and one female with HIV were asked to facilitate in the awareness raising session in one of the first STOP AIDS NOW! training events, where an anti-discrimination tool kit was introduced.

Table 9: Ways 406 staff reported being affected by HIV and AIDS (multiple response)

Ways staff were affected	Per cent
• Attending burials	51.7
• Taking care of a sick family member	31.0
• Caring for the bereaved	29.9
• Increased medical bills	20.4
• Reduced personal health	5.4
• Other	4.8
• Not affected	28.7

Table 10: Affect of HIV and AIDS on the work floor, reported by 406 respondents (multiple response)

Ways performance was affected	Per cent
• No impact	42.9
• Increased absenteeism due to illness of family members and burials	31.5 15.0 8.9
• Increased workload due to illness of other staff	8.1
• Reduced performance due to personal weakness	
• Increased absenteeism due to personal illness	

PLHIV at lead organisation level

lead organisations reported trying to involve PLHIV as much as possible in their activities, mainly done through networking with organizations of PLHIV, including NACWOLA, DNPLHN, and NAFOPHANU. Activities which PLHIV are involved in include:

- *IEC*, where drama groups of PLHIV are asked to perform during VCT days and other events, e.g. TASO, AIC, Mildmay.
- *VCT* activities, for instance VCT days, where PLHIV are asked to help with the counselling of people coming for testing.
- *Training*, where they are asked to give talks about positive prevention, the ABC strategy, and living positively.

PLHIV at CSO level

lead organisations reported that CSOs in their areas involve PLHIV in various ways, by:

- Inviting them during HIV and AIDS internal sessions
- Involving them in project design, for instance the drafting of workplace policies
- Having a saving scheme for them (village savings and loans associations for PLHIV)
- Employing PLHIV and providing them with treatment, care, and support (loans advances).

4.6.3 Case studies of PLHIV involvement in organizations

In data collection for the end report we asked six CSOs whether and how they involve PLHIV in their workplace policy, and also in external activities. The cases of the five CSOs below show that they involve PLHIV to make staff and beneficiaries aware of living positively, and to motivate them to get tested, to disclose, and to go against stigma and discrimination. This is done by PLHIV participating in training and events, and having them as peer educators and giving testimonies.

"We tend to take HIV positive people to showcase, but only those who are willing to disclose. Else we just tell their stories, but do not mention names. We cite examples of HIV positive people – like some politicians, etc. – to show that they can live normal lives. In schools there is less disclosure of status among teachers due to fear of stigma and discrimination (LABE's core business is adult education). So because we are knowledgeable, we find it necessary to carry over the same message to our target groups." (LABE)

"EASSI involves PLHIV in many of activities and asks them to tell their experiences in training for staff. Also, we have done an HIV and AIDS awareness campaign for the neighbourhood community and some EASSI partners. This was done on the AIDS day and we invited HIV positive people to testify. On the same day, Mildmay (a VCT provider) was invited to carry out VCT and over 99 people tested. On an annual basis, this will be done. We invite different PLHIV from different groups, for instance representing discordant couples, young men and women, married, pregnant etc. to show positive living, so people can follow their example and fear of stigma will reduce." (EASSI)

"A program was supported by NUDIPU in Gulu that mobilized women with disabilities living with HIV and AIDS; 38 came up. We sensitized them on positive living. However, disabled people develop self stigma and are stigmatized by others: people tend to say, you are a disabled person and yet you have acquired HIV and AIDS, people tend to point a finger at them. In training, VCT is integrated to enable the disabled women to know their status. We advised them to form groups for better access to services. So in these trainings we involve HIV positive women to willingly give testimonies to encourage positive living." (NUDIPU)

"On Fridays we have journal clubs where we have some people living positively who come up to talk to staff on issues related to HIV and AIDS. The HIV Coordinator is HIV positive, as well as some nurses and a driver, and all play important roles in our HIV activities. The driver, for example, is one of the most active in the peer club, helping distribute condoms whenever we go out to communities. We have outreach centres where peer educators go and educate members of the public. Some of these peer educators are HIV positive, and that is why we involve them to identify, train, educate, and refer other HIV positive people here, where they can get HIV care and support. We have 40 volunteers per site and every Tuesday we have what we call Hospice day care, where these volunteers come along with the HIV patients for psychosocial care and support. We have a team of social workers and physiotherapists who train the volunteers/peer educators to handle the psychosocial needs of patients. The volunteers also do the identification and referral services for HIV positive persons in the communities they stay in." (Hospice Africa Uganda)

"We have groups of people living with HIV and AIDS and we involve these groups in HIV activities. Mostly we do it through what is called interactive intervention, where these communities meet and share experiences. We also have children's game groups where we involve them in recreational activities; the children we find in schools, and mostly they are children we have seen before and so we continue with them. But this particular project was intended to identify children who are infected and affected by HIV and AIDS." (TPO)

4.7 Sustainability

The STOP AIDS NOW! project lasted until the end of 2008. From the start, however, all stakeholders in the project structure, including project coordination and CSOs, have been advised to think about sustainability of the workplace policy activities, financially, organizationally, and regarding knowledge.

4.7.1 Sustainability measures at project level

The conclusion of the participants in the local project group workshop was that the project is sustainable. It was originally a three year pilot, and it has already received an extension for two years as a consortium with funding through the Civil Society Basket Fund. Within the local project group there is enthusiasm to continue.

The local project group chairman explained that discussions are ongoing in the local project group on how to continue with the project further. Under the two year Civil Society Basket funding, ACORD is the grantee. STOP AIDS NOW! will still support 40% of the budget during these two years. When STOP AIDS NOW! pulls out funding activities, it may become either a project run by ACORD, or an independent organization. There is a lot of experience and know how in the project – they could serve as consultants in future capacity building – which could attract funding. The local project group believes that they should lobby by marketing the Good Donorship Guidelines and budgeting tool to other donors and share their experiences in conferences. A consultation meeting will be held once the new project poordinator, who started in February 2009, is settled in his job. In fact, in the terms of reference for the new co-ordinator, a major requirement was skills and experience in advocacy and fundraising, which can be considered a sustainability measure.

From their side, the project office sensitizes and advices partner organizations to move beyond the project and STOP AIDS NOW! donorship and think of other donors to sustain the project and workplace policy. For sustainability, they advise CSOs firstly to use the tools and workplace policy guidelines as an advocacy message to other donors, and secondly to make the policies institutional tools so that they are accounted for in the general budget.

4.7.2 Sustainability measures at CSO level

Most organizations in AR2 that had a (final) workplace policy and activity plan reported that they had put in place or planned sustainability measures in case the STOP AIDS NOW! donor funding would stop; they did

this in various ways, either through the regular budget, or as a specially funded project for which (another) donor had to be found, or a combination of the two.

In AR3, most CSOs, 26 out of 28, had measures in place to sustain their workplace policy for when STOP AIDS NOW! donor support will stop. Their sustainability strategies include:

1 Training their own peer educators
2 Writing proposals for funding
3 Mainstreaming HIV and AIDS in other organizational budgets; and
4 Having internal fundraising mechanisms (these are elaborated on below).

1 Training peer educator

Because training and information sharing is a continuous process, some organizations have thought it wise to train their own peer educators to carry on with training other staff, even when the STOP AIDS NOW! project and its funding have stopped. It was on such grounds that one of the respondents said that:

" ...we have peer educators. They were trained at the end of last year. So without funding, I believe they can still continue to do their work. Even the sensitization – we have the HIV and AIDS focal persons in each and every health centre. So without the funding, we can still continue." (ACORD)

2 Writing proposals for funding from other sources:

Four organizations emphasized that they could use the workplace policy guidelines, as presented in the Good Donorship Guidelines and budgeting tool, to write project and budget proposals to other donors in order to run the stipulated activities in the workplace policy. They also consider the workplace policy to be a lobbying tool for funding, as demonstrated in the following phrase:

"Because by the time we were developing our policy, our manager was saying, apart from giving us a conducive environment for sensitization, treatment, and support, it is going to be a tool for lobbying. We shall use it as a tool, even the local government can give us funds." (KADP)

3 Mainstreaming HIV and AIDS in other budgets

Realising that dealing with HIV as an isolated issue requires more funds and may not be sustainable, some organizations have resorted to mainstreaming HIV and AIDS related activities.

"The way we were trained, but now having had the last training in Kampala last year, the mainstreaming in programming, we realized it was needed so that it does not stand alone. And having taken HIV as a cross cutting issue, we realized it is now important for incorporation in other programs and in other policies available at the office." (FURA)

4 Internal fundraising mechanisms

Those organizations that have embraced workplace policy are really committed to dealing with HIV and AIDS at their place of work, and this can be demonstrated in the levels and amounts of resources they have and continue to put in, as the following quote summarizes:

"Quite almost everything, because even the computers we use here; the telephones we use to communicate between our partners when we are organizing for such functions between EASSI, STOP AIDS NOW!, service providers, we use telephone; we use what, we use stationary when we have such workshops like on VCT, we spend a lot of money on stationery while organizing; you know and I allocate twenty hours for HIV and AIDS per month... All those are resources but we have created space for it and the budget line for it. We have a committee which meets every month to discuss the progress of the workplace policy implementation." (EASSI)

Other organizations are involved in various methods of resource mobilization to fund workplace policy as a sign of commitment towards achieving the goal of dealing with HIV and AIDS in the workplace. For example, the BUSO Foundation is looking to farming as an alternative source of resource mobilization. As the Executive Director said:

"We are venturing into cultivation of cereals to improve on our source of finances and this will help us meet some of our set objectives."

Such internal mechanisms of raising funds may include member's own contributions, as is reportedly done in AMFIU:

"We have some other avenues of getting some internally generated income. We charge membership fee, we have publications which we sell, and we are trying to develop our resource centre so that it can earn something."

VEDCO intends to ask all their funders to always add an administrative fee to the funds awarded them; this money VEDCO can direct towards activities of the workplace policy, as the focal point person explains:

"We are developing a resource mobilization policy, like for example, before we jump into any monies from some donor, we must have our own condition that is to be filled, like if we are saying that every money we get there must be an administrative fee maybe of 5%. The same thing is going to apply to some of these things. There must be a contribution towards HIV and AIDS workplace policy support of a certain percentage which we have not yet agreed upon. But that means every project that comes on board as long as they are our projects; by policy there will an allocation on the budget towards that cause."

4.7.3 Challenges to sustainability

A challenge to the sustainability of workplace policies in organizations, mentioned by the local project group chair, is loss of institutional memory and thus enthusiasm. He observed that for some organizations there is inconsistency in attendance to training and meetings by representatives. Because of staff turnover, new executive managers and directors may not be aware of and motivated to STOP AIDS NOW!, and may query an focal point person who is attending a whole day meeting of STOP AIDS NOW!; the person attending may not be a decision maker. Thus continuous sensitization has to take place.

Focusing on specific effects

5.1 Linking and learning and social networking

One of the objectives of the STOP AIDS NOW! project was to provide linking and learning opportunities, with one of the aims being increased social networking to facilitate implementation of workplace policy activities. The project has provided many opportunities for linking and learning, and facilitated linkages for education, training, and services, not only between CSOs but also with other stakeholders. The project used a multi stakeholder approach which means always involving relevant government institutions, international CSOs, and national CSOs – for instance of PLHIV – and private sector organizations (for example service providers and insurance companies) in STOP AIDS NOW! workshops and activities. Linking and learning has taken place at project level and at CSO level, as will be discussed below.

5.1.1 Learning within local project group and networking beyond

During the workshop with the local project group, participants reflected on how they had learned from being a member of the local project group. Since the local project group consists of 9 strong organizations with different backgrounds and core businesses (for instance capacity building, gender, training, HIV and AIDS), and brings together their extensive networks, they learn from one another in local project group meetings and activities and share their networks. local project group members expressed that they especially learned from the contribution of NAFOPHANU, the network of PLHIV. The host of the project coordinator is a strong organization with a wide network, and by physical closeness the project coordinator and host organization benefit from each other's networks and materials, and can consult on a daily basis.

Local project group members reported to have learned from outside expertise on workplace policy through co-reviewing the draft policies with specialists, e.g. from ILO and Oxfam International, who were members of the draft workplace policy review team. They said that sharing STOP AIDS NOW! documents and AR reports with non-STOP AIDS NOW! organizations helped to share experiences and gain knowledge.

The local project group provides guidance to the project office by advising (outside) stakeholders for the programme. After the Dutch project coordinator advised on the formation of the lead organisation model when it appeared that the project coordinator could not cover the whole country, the local project group wrote Terms of Reference for lead organisations and provided guidelines (MOU) that have enabled the lead organisations to create more social networks on their own. According to their Terms of Reference, lead organisations are supposed to create social networks for partner organizations in their region. Table 11 summarizes the organizations which the local project group, project coordinator, and lead organisations network with, and the purpose of networking. The Dutch project coordinator has been facilitating many of these networks during her visits to Uganda.

Organizations not mentioned are Uganda Business Coalition, UNAIDS, and Part Project (information by Dutch project coordinator). As can be seen from Table11, the project coordinator, local project group and lead organisations network for purposes of lobbying and advocacy (for example shaping policies), resource mobilization, exchange of knowledge, capacity building and experiences (of workplace policy), service provision (HIV counselling, VCT, insurance schemes), preventive measures (condoms), and training. Most of the services, including IEC materials, condoms, and VCT, and capacity building are free of charge – sometimes a small fee for transport has to be provided to the organization providing these services.

Lead organisations facilitate the social networking for the CSOs in their region by putting them into contact – then the organizations may sustain the networks themselves. Without the intermediary role of the lead organisations, CSOs may get condoms themselves from the MOH, get IEC materials, invite drama groups through Makerere University and Johns Hopkins University (MUJHU) for their organization of family awareness raising days, or by invite Mildmay for a VCT day, etc.

5.1.2 Networking by CSOs

The fact that the 76 CSOs are members of the STOP AIDS NOW! project provides them with linking and learning opportunities through attending STOP AIDS NOW! workshops and getting information through the project office. The 76 partner organizations also form a social network which exchanges and shares information and experiences, especially during training and by participating in events. This was already reported and appreciated by organizations in AR1.

In AR2 most participating organizations reported to have established links with other organizations and service providers beyond the STOP AIDS NOW! network. These links have been very beneficial for the implementation of their workplace policy. They were found to be networking and collaborating with training institutions, service providers, information organizations, etc., to be able to implement their policy with minimal cost. Examples of such links and networks for selected CSOs are illustrated in Table 12.

Networking reduces the cost of workplace policy implementation, may enlighten service providers to the plight of specific groups, and also provides service organizations with an easy to reach target group, as the following CSO experiences show.

"You can have a policy without having to spend much money, because you can link up and build networks with service organizations that do not require money, or only little for lunch." (EASSI)

"Service providers provide services in our advocacy activities, but also learn. They now see the need to help the women with disability especially those who are HIV positive. Before, many would think disabled women do not have sexual feelings and always have been left out during service delivery." (NUWODU)

Table 11: Organizations with which project coordinator, lead organisations, and the local project group established networks, and for which perceived purposes

Organization	Network purpose
• Ministry of Health (National and District)	• Condoms, IEC materials, participating in meetings
• Federation of Ugandan Employers	• Provide facilitators in STOP AIDS NOW! capacity building activities, give IEC
• School of Public Health	• Capacity building (training in HIV counselling, monitoring and evaluation)
• District AIDS committees (DAC)	• Lead organisation sitting in advisory committees
• NACWOLA	• Participating in meetings (link in the social network)
• Mildmay	• IEC and provide VCT (come during VCT days organized by (lead) organizations)
• Uganda AIDS Commission	• Director general was invited to give speech at the launch of STOP AIDS NOW! project
• AIDS Information Centre (AIC)	• Technical support services, information and fundraising opportunities
• ILO	• Technical support, participating in workplace policy review meetings, facilitate sessions during training and in capacity building workshops
• NAFOPHANU, UNASO, TASO	• Advocacy and information sharing
• Micro Care, AAR, IAA	• Health Insurance
• INTRAC, JOHMET	• Sharing expertise and networks with like minded organizations in workplace policy programming
• SNV	• Training in mainstreaming

Table 12: CSOs linking with other organizations, and purpose

CSO	Network partner	IEC materials	Counselling	Condoms	Training	VCT
TAP	Uganda CARES and MOH	•		•		
Africa 2000	TASO		•			
NOGAMU	Epopa and NACWOLA			•		
SOMED	Masindi Hospital		•			
Health Need	Uganda CARES		•			
Fura	District Health Service		•	•		
LABE	TASO and AIC	•		•	•	
UMFL	JCRC, Mildmay and AIC		•			•
Vision TERUDO	AIC					•
BUSO Foundation	ACORD and MOH	•		•		

"We are currently networking with TUSAPA (The Uganda Students AIDS Prevention Association) which works in three districts, i.e. Wakiso, Kampala, and Mukono, and they do awareness creation. We link the fishing communities to HIV and AIDS service providers like health centres to access the VCT services." (UFFCA)

5.2 Access to services

Through the workplace policy access to HIV and AIDS services has been facilitated for staff. Which services would be provided by the CSO was often a point of discussion when developing a workplace policy, however, and CSOs feared the financial implications of a commitment in the workplace policy to providing access to VCT, ART, and treatment of opportunistic infections, either through insurance or direct payment. Provision of condoms for staff has also been a contested issue, especially in FBOs.

The project office, local project group, and lead organisations facilitated access for CSOs by linking them to service providers. This was done by providing information and training to staff to provide the services themselves (for instance counselling), or by physically bringing the materials of service providers to be able to link with them during supervision visits. AR3 studied the effects of workplace policy concerning access to services, which are summarized in Table 13, differentiating the role of project coordinator, lead organisations, the local project group, and the CSOs.

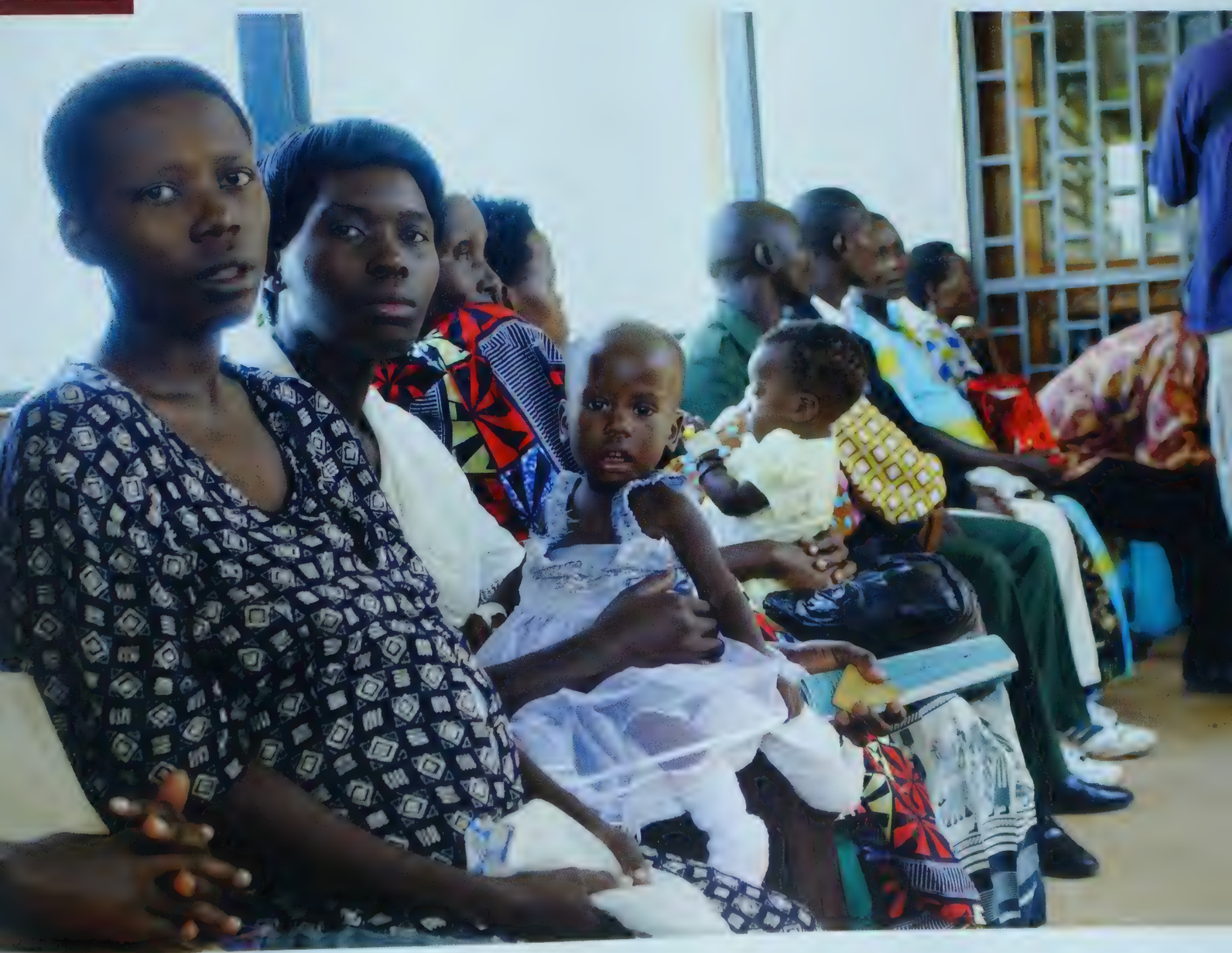


Table 13: Effect of workplace policy on access to different services, at STOP AIDS NOW! structure, CSO, and staff level

Service	Facilitation by PC, LOs and LPG to NGOs	Facilitation by NGO for staff (AR3=29 NGOs)
IEC	• Provided link with providers, and physically provided: posters, booklets, T-shirts, leaflets, guidelines, reports, and videotapes about workplace policy • Designed T-shirts (with HIV and AIDS messages) and distributed them to focal point person in CSOs • Brokered between CSOs and designer of IEC to adapt messages for certain target audience (for instance NUDIPU for people with disabilities)	• AR3: Awareness raising (in 28 CSOs), through routine discussions (19), internal training for staff (11), or training by external trainers • AR3: IEC materials displayed on notice boards (17) or in AIDS Corners (12)
Counselling	• Training peer educators in CSOs • Providing information about counselling services/service providers	• AR3: Peer (one-to-one) counselling (9)
Prevention / condoms	• Acquired condoms from Research Triangle Institute (RTI), MOH, and UN High Commissioner for Refugees, and distributed them to CSOs • Lobby with FBOs to consider condom promotion for staff • Lead organisations provided "pass by" condom pick up services for staff in CSOs where no condoms were provided	• In AR1: 10/16 CSOs in case studies provided or wanted to provide condoms • In AR2: 19/72 CSOs provided condoms • In AR3: 18/29 CSOs provided condoms for staff
VCT	• Mobilized VCT kits from local government (District Health Centres), RTI, Mildmay, AIC, etc. for CSOs • Organized VCT events together with partner CSOs: mobilized financial resources, organized drama groups, hired VCT services providers for CSOs	• In AR3: Promotion of VCT (19)
ART / health services	• Information on ART and health services providers • Encouraged CSOs to consider health insurance schemes • Brokered between CSOs and insurance companies like AAR, Micro Care and IAA to negotiate low premiums for insurance schemes	• AR2: 19/72 facilitated access to treatment • AR3: 10 CSOs facilitated access to ART for staff – by arrangements with a private facility (6), by health insurance (4)
Care and support	• Information about service providers	• AR3: Measures to support HIV positive staff (7). The few CSOs with sick staff refer them to service organizations such as TASO which provide care and support including provision of food

In AR2 there was routine condom promotion and provision reported in 19 organizations. Condoms are put in places of convenience such as washrooms where staff members feel comfortable to pick them up as and when they want; some also have condoms in their First Aid box. For those organizations providing condoms, it was reported that the uptake was high. Two FBOs also provided condoms, although they are supposed to be used only for family planning. A participant in an focus group discussion in one of the FBOs said:

"It does not distort our prayer mission of spreading the gospel of Christ. We normally put the condom behind and the bible in front. That is our mission." (focus group discussion KARUDEC)

AR2 found that 19 CSOs provided access to ART, through insurance schemes (5), (part) paying for treatment (2), or CSOs in health service delivery providing free ART for staff. Other organizations, including Concern, FAPAD, and Raising Voices, give support to their HIV positive staff members by linking them to the Uganda Joint Clinic Research Centre (UJCRC) or other centres, which provide free ART, CD4 counts, and other AIDS specialized care. Concern specified they have drawn a memorandum of understanding (MOU) with UJCRC to treat their staff. ACORD-Gulu specified how they facilitate access to free services and give time off for their staff to get their treatment:

"Now there are a lot of free ARVs in the district ... Any time one can write that: 'I am not attending today's office. I will be out following my treatment.' So we can take it for granted that that is the right information. And the doctor presents us with a voucher ... if he has counselled somebody, he has maybe prescribed somebody drugs. ... And even he can get that type of drug, but the rest is almost free." (In Depth Interview(s), ACORD-Gulu)

AR3, which was to measure the effect of workplace policy, asked 236 staff in a survey whether they had access to a wide range of HIV and AIDS related services, and whether they participated or made use of the services provided. (The number of CSOs providing the services is presented in Table 13.)

Seventy-four per cent know about *awareness raising activities* in their organization, and the majority (84%) of those who knew about them participated in such activities. Routine discussions in the workplace were reported by 66%, and special training for staff by 50% of staff. Concerning IEC materials, 76% of staff reported that such materials were provided in the office and also that they looked at them.

Sixty-nine per cent of staff worked in organizations which reportedly *promote VCT*, and 19.9% of staff said that the workplace policy had motivated them to go for VCT. Others already went on their own initiative or had to go for testing when they were getting married, or had routine testing when in the hospital or while pregnant. VCT uptake among staff in the CSOs was high, with 65.3%, compared to the national average of around 13% (WHO 2007).[6]

In AR1, 27% of staff reported condom provision in the workplace, while this figure increased to 66.1% in AR3. In AR3, 50.6% of those who knew about condoms in the workplace also took them, at least sometimes. Of all staff in AR3, 33.4% get condoms from the workplace.

Concerning staff knowing of the provision of ART through their CSO in AR3, 22.9% of staff said their organization facilitates access, 39.0% said their organization does not have such provision, and a considerable number, 38.6% of staff, did not know whether their organization provides access to ART or not.

The majority of staff (76.7%) in AR3 trusted that their organization will support HIV positive staff.

5.3 Influence of internal mainstreaming on external mainstreaming

Theoretically, the internal mainstreaming of HIV and AIDS will influence and can be beneficial to the execution of programmes with an organization's beneficiaries. During data collection in January 2009, we talked to HIV focal point persons and/or managers in 6 CSOs about the influence of internal on external mainstreaming in their organization.

[6] WHO (2007). Towards universal access. Scaling up priority HV/AIDS interventions in the health sector, Progress report, April 2007. www.who.int/hiv/mediacentre/universal_access_progress_report_en.pdf

It was found that the CSOs which did not have health or AIDS as their (core) business had started or had intensified discussion about HIV and AIDS with their beneficiaries, and some had tried to mainstream HIV and AIDS in all their programmes. According to the respondents, developing an HIV and AIDS workplace policy has helped staff to become knowledgeable and conversant with HIV and AIDS issues, also in their work with beneficiaries. It was also recognized that external mainstreaming does not have to cost extra money, because it becomes an integral part of the projects. For instance, LABE has a module on AIDS in their education programme. The following presents case studies of how CSOs started external mainstreaming.
LABE's main concern is adult literacy. The focal point person and the regional manager of Northern Uganda, where most of their programmes take place, explained how about one year after they entered the STOP AIDS NOW! programme and had the training, they were convinced of the importance of mainstreaming HIV and AIDS in all their programme activities – including already existing ones. For instance, LABE organizes Adult Literacy Classes for parents, comprising of 80% mothers and 20% fathers.

"Initially, we had thought it was because of cultural taboos that the communities in our area of operation feared to talk about HIV and AIDS, but from the survey conducted it was found out that they (parents) had less knowledge and information on HIV and AIDS. So now the read and write modules developed include HIV and AIDS issues. The training method is to carry illustrations for the participants to interpret and brainstorm."

The focal point person of UFFCA, an organization for fishermen, explains how they try to create awareness about HIV and AIDS in the fishing community:

"We started intensively doing external mainstreaming after becoming more knowledgeable of HIV and AIDS internally. Just like us, the fishing communities we work with are affected by HIV and AIDS. We do awareness creation through public debates, direct contact, and trained champions, counsellors, peer educators, drama units, etc."

FURA is concerned with loans and rural development. The focal point person explained how they mainstream HIV and AIDS in their activities:

"When we talk in the communities about loans, we also talk about AIDS and prevention. Because of the workplace policy, staff members are now knowledgeable about HIV and AIDS and talk about it in the communities. That is not difficult, because we have been given knowledge. (However, it happened that one of our colleagues was chased out of a community meeting because he was talking about condoms. They said they did not want FURA again.) We plan to select peer educators in the community to train them on talking about AIDS. We are working at the moment with over 10,000 clients in this programme. So whenever we are in the field we are talking about that kind of thing or we are asking someone to come and talk about it."

EASSI is a regional network of CSOs concerned with women's rights. In EASSI, external mainstreaming was already happening before they started internal mainstreaming. They had mainstreamed HIV and AIDS in their strategic plan (2005-2008) when they realized it was not possible to talk about rights for women without addressing AIDS. Then with the STOP AIDS NOW! project they realized that they should also do something for their own workers and started participatory development of the workplace policy. The director reported that they now try to advise their co-members within and outside Uganda to develop a workplace policy – which may be considered external mainstreaming. They sensitize them in meetings, during which co-members shared their difficulties with taking care of and supporting sick staff. This was done in an ad hoc way and could have been dealt with better through a workplace policy.

NUWODU is working for women with disabilities. The director explains that they are reviewing their strategic plan and want to mainstream HIV and AIDS in it. They have invited HIV and AIDS stakeholders like TASO, UNASO, and STOP AIDS NOW!, to give technical input. There has already been a spill-over effect of the workplace policy because staff carry on the knowledge they have acquired through the workplace policy to the community, such as prevention skills. Condoms

are also given to the community, and they have tried to link the community to service providers. The director commented:

"Before the workplace policy, HIV and AIDS activities were happening on slow motion, but now policy activities have intensified the mainstreaming of HIV and AIDS in the organization's interventions."

TPO is concerned with providing psychosocial support and mental health care in (post) conflict settings. The assistant focal point person explains how they now have activities related to HIV and AIDS in the community, which are also funded:

"Our internal HIV mainstreaming helped us to come up with a proposal which was accepted and we got funds which are going to run for 3 years. This is because we realized we had a workplace policy which is between us employees and the employer, but HIV also affects the community, then secondly, the workplace policy has impacted on us in a way that we are able to take that which happens here to the community. It has to be confidential, non discriminative when you take it – HIV services – to the community. We also have linkages which have helped us to diversify in a way, because we have signed an MOU with AIC to carry out community VCT outreach services and we also signed an MOU with a clinical psychologist and a medical consultant who is helping us to build the intervention of medical whole view of HIV and AIDS to people. This project in Katakwi gets condoms from the local government which is part of our linkage through workplace policy. We also get some IEC materials which I got from the STOP AIDS NOW! project and they use them."

5.4 Stigma reduction

Already in AR2, when implementation had just started, it was reported that there were fewer instances of stigma and discrimination against HIV positive people. Previously, HIV positive staff could not openly talk about their HIV status because it automatically meant losing their job. Concern reported that retaining infected staff has helped to reduce stigma and discrimination. A sign of reduced stigma, and of not considering AIDS as shameful, was reported in the focus group discussion in LABE:

"I no longer hide telling colleagues that I have lost a relative to AIDS."

Focus group discussion participants in SOMED shared how they had lost one staff member, but showed solidarity with him until he died. In BUSO they had an HIV positive staff member before, who left because of stigmatization. They have someone now as well, but they discuss things freely with the person to manage the situation.

In AR3 managers reported that feared stigma and discrimination have reduced because of the participatory development of the workplace policy and various workplace policy activities. At the organizational level, 62% of CSOs reported stigma reduction within the workplace because of the workplace policy (in other CSOs there already was reportedly no stigmatization), and 55% of staff reported having a changed, more understanding attitude towards PLHIV – indicating reduced intention to stigmatize.

Sensitization and awareness raising sessions, undertaken by all organizations as a first activity, created more knowledge and openness concerning HIV and AIDS among staff in the organizations; 64% of staff felt there is more openness to talk about HIV and AIDS with their fellow workers. The openness has also led to the fact that more staff members intend to disclose their status in the workplace if they would find themselves to be HIV positive, indicating that they do not fear stigma: 50% said they would now disclose their status, while 15% said they would already have disclosed, and 38% would still not disclose. They trust they will be supported by their organization and do not fear losing their job. Of staff members, 50% now feel supported by their organization, whereas 35% already felt supported, and 15% do not feel supported. Almost all staff, 88%, are now confident they would not lose their job if HIV positive. The following cases show how HIV stigma has been reduced in CSOs, which facilitates disclosure.

"In our programs we partner with the AIDS Information Centre to sensitize our groups on issues of HIV and AIDS. But we also made sure that the staff got that knowledge. And through that they are now more aware. I think it is, if people tested now and found out that they are positive they would be able to come out very openly. Because we had a staff who tested positive and was really a very good advocate and encouraged people to test and let others know about their HIV status. Unfortunately the staff died two months ago, but – you know – he was like, you know – encouraging people and telling people that – you know – you people you are here, you think you are okay, you are healthy and what have you, but you might not know that you could die. So it is better for you to know your status, and he would talk about himself – you know... " (CEFORD)

"Staff members are actually taking it as a major concern that HIV and AIDS is not to be taken as – you know, previously it was taken as a disease for people who are – I don't know which term I would use – you know, people were taking it to be a disease of people who go reckless. But now people consider it to be just like any other disease. So this kind of stigma, of saying that maybe you got it from wherever I don't know, I think that thing has now gone out of people's minds." (KALI)

"At the moment two staff have disclosed that they are HIV positive. This is majorly because they are sure of the organization's support as a result of the policy obligations like treatment, care, and support. If an organization doesn't have such a policy in place staff will always hide because they see no benefit in disclosing other than being stigmatized and discriminated." (KADP)

Stigma reduction in the community may take place as a spill-over effect of the workplace policy, because 46% of staff members reported that they discuss the information they get in the workplace with their family and friends; this will be further discussed in 5.5.

5.4.1 A note on stigma reduction

Although most CSOs reported reduction of HIV related stigma, stigma is still brought up as a challenge to workplace policy implementation, and staff who would not want to disclose said this is because they fear stigmatization by their peers. Two master students conducted qualitative studies of stigma in four CSOs (see methodology). They found that there were no instances of enacted stigma, but that associations of immorality and death still linger in staff's minds. The label of immorality prevailed, especially in FBOs and among young unmarried staff, who fear it will be difficult to find a marriage partner when HIV positive. An interesting finding was that staff did not so much fear stigmatization by other staff, but were afraid of self stigma – they feared being traumatized and feeling useless and guilty if they were HIV positive. Staff of CSOs in AIDS work, who work with HIV positive communities, associate AIDS less with death than staff who do not. The former have seen more examples of positive living with HIV. Further, staff in CSOs with HIV positive staff also associated HIV less with death. It was found in these studies, however, that a risk of the workplace policies is that they increase stigma through positive discrimination, by singling out HIV positive staff for separate services.

5.5
Spill-over effects

As a result of developing and implementing workplace policies, it was reported that staff's knowledge base increased, and this also meant that their perceptions towards AIDS changed, which may in turn mean that stigma and discrimination also reduce. However, it appeared that workplace policy discussions and activities reach further than the workplace, even without intentionally involving people outside, such as is done during VCT days or when also letting family members receive benefits through the workplace policy.

In 10 of the 29 CSOs in AR3, managers reported that family are more involved because of the workplace policy. CSOs involved staff's family and also surrounding community members in workplace policy activities such as VCT days and IEC campaigns. Most organizations said that they desired to include not only the staff in the benefits of the workplace policy but also his/her family members. In situations where the workplace policy only caters for staff members, it has been because of the budget limitations; otherwise, the issue of the policy catering for only staff became a point of contention during development, especially about who is and who is not covered by the workplace policy. It was felt that family should be involved because staff and therefore the workplace are affected by HIV when a family member is infected or affected, and vice versa.

"We are targeting the relatives of staff. I don't know whether other organizations are looking at that but for us we are targeting that; you cannot support the staff as an individual, also family members need to benefit." (CEFORD)

"I think actually the main thing is the openness. I think there was no way we could start discussing our private family affairs before, but in this aspect we are discussing serious family issues, especially in fact recently we were with the Uganda Women's Network and we were discussing the will making. So I think that is key." (OWUNET)

Without specific activities, the social networks of staff also benefit from the workplace policy. Already in the AR1 survey it was found that the knowledge that 161 staff gained from IEC sessions was reportedly being shared with family (69.9%) and friends (64.9%). In AR3 we asked more systematically about this. It is a promising development that the majority (90.2%) of the 123 staff who had received training said they shared what they had learned with others. They reported to share the information with family (31.5%), friends and peers (30.6%), their spouse (10.8%), and community members (6.3%). One person said he shared the information in his church – and thus reaching a large audience.

Almost half of the staff (46.2%) reported that because of the workplace policy they are now discussing AIDS more with family and friends outside the workplace – which can be considered a spill-over effect of the workplace policy. The 85 who reported on what they mainly talked about said:

1. Prevention and protection from HIV (60%)
2. VCT (15.3%)
3. How the workplace policy supports staff (11.8%); and
4. Stigma and discrimination (7.1%). Five staff said they talked about how to care for the sick (5.9%).

However, it is not only information which is shared outside the office, but also condoms. In AR3 it was found that staff who get condoms at work do not necessarily use them all themselves. Managers in the In Depth Interview(s) said they suspect, and this was confirmed by findings from the survey, that staff take condoms for others. Of the 82 staff who reported on this, 45.1% used the condoms for themselves only, 40.2% used them for themselves *and* for others, while 14.6% took condoms only for others. If those others were specified, they were mainly friends, brothers, youth ('who may not have money to buy them', 'to safeguard them'), neighbours, or others who cannot access them easily. One woman said:

"I get them from the office for others, because myself, I don't. I am faithful to my husband who doesn't even need them."

6 Lessons learnt and recommendations

From this report we can extract promising practices and also challenges, at project and CSO level, which can serve as input for the recommendations at the end of this chapter. Recommendations will be directed to the CSOs, project and to future projects.

6.1 Promising practices

6.1.1 Project level

Project structure
The STOP AIDS NOW! project structure, with local ownership by a steering committee (local project group) of strong CSOs with a wide network, is a promising practice. The local project group decision to install lead organizations in the regions was a wise practice.

Capacity building by the STOP AIDS NOW! project
The capacity building facilitated by the project office and partners is a good practice. CSOs were highly motivated by the training. Besides building knowledge and skills, this training provided a forum where CSOs could exchange experiences with peer CSOs and network. Starting capacity building with sensitizing CSO directors and senior managers is considered best practice to get CSOs initiated on workplace policy development.

Adaptability
It is a good practice to adapt to upcoming challenges with practical solutions. The budgeting tool 'What's it likely to cost' was written in the course of the project when it appeared that budgeting was a problem for many organizations (not knowing what could be included and how to make a budget).

Write proposal for funding during STOP AIDS NOW! project period
A good practice was to scout for funding opportunities during the STOP AIDS NOW! project period. The project coordinator and local project group have put in a proposal and were granted funds from the Civil Society Basket Fund to continue the activities that were started under the STOP AIDS NOW! project.

6.1.2 CSO level

Participatory workplace policy development
A participatory workplace policy process, involving all staff, is a way to sensitize staff and create opportunities for more open discussions about HIV and AIDS. It also facilitates workplace policy development and implementation when senior management are committed and the board gives support.

Promote VCT
Promoting VCT through a VCT day, where family members and neighbours are also invited, is a good practice. Not only does it increase uptake of VCT, but it also generates more open discussions about HIV and AIDS. One CSO said that they hold a VCT family day (involving family and friends) instead of an end of year party:

> "It is a kind of get-together when staff meet to talk about HIV and AIDS issues, including preventive measures like faithfulness. On the same day VCT is carried out for staff and their families to know their status so as to plan. Instead [h]aving an end of year party for the staff/organization, instead we call it a family day.

Starting activities which do not require much funding
It is a promising practice that organizations have started implementing their workplace policy before it is finalized and funded.

Networking
A good practice is that organizations network with Government, other CSOs (national and international), UN agencies, and the private sector, for IEC, preventive measures (condoms), counselling, and (free) service provision.

Education and training
Education and training of staff is always a good practice. Specific promising practices include awareness raising sessions by technical staff training support staff.

IEC and prevention materials
A good practice is to make information on HIV and AIDS available in the organization, for instance in AIDS corners or on notice boards. If decided in a democratic way, it is a good practice to let staff have access to condoms in the workplace.

Involvement of PLHIV
Involvement of PLHIV is always good practice, and this has been strived for at project and CSO level. When inviting PLHIV for sensitization and training it is good to look for people whom the target group can relate to, such as EASSI and NUDIPU did. They got testimonies from, for instance, discordant couples, married women, young men and women, a woman who had a child while HIV positive, and women with disabilities. In conclusion, use HIV positive peer educators.

Update other staff on training
It is a good practice for staff who have gone for training to give routine feedback to other staff, as the focal point person of one CSO commented:

"If you invest only in one person, you may lose out. So it is always better to at least have more staff knowledgeable of the workplace policy."

Putting in place sustainability measures
Already thinking about the sustainability of projects, and putting in place sustainability measures before the end of a project, are good practices. CSOs were training their own peer educators, writing proposals for funding – possibly using the STOP AIDS NOW! guidelines – mainstreaming HIV and AIDS in other organizational budgets, putting the workplace policy in the organizational work plan, and conducting internal fundraising mechanisms for workplace policy activities.

Having an focal point person with dedicated time
CSO management assigning an focal point person with a clear terms of reference and dedicated time is a good practice. A well functioning focal point person was found to facilitate workplace policy implementation and reporting to the project coordinator office.

6.2 Challenges

Lack of skills for workplace policy development
AR1 found that not all CSOs had sufficient skills to develop a workplace policy. Some workplace policies were too general and missed important ingredients, such as addressing gender, anti-discrimination, and eligibility. Many CSOs which had activity plans and budgets attached found that their budgets were too high, and included items which should not be part of the workplace policy budget, but should be in the regular budget.

High staff turnover
High staff turnover causes loss of institutional memory, also related to workplace policy. Many times it happened that trained staff left an organization, or were assigned another duty. New executive managers and directors also may not be aware and motivated to manage HIV and AIDS in the workplace.

Financial constraints
Finances are always a constraint, at project and CSO level. Most CSOs have not received funding from their donors, including the STOP AIDS NOW! donor, for their workplace policy activities, which may cause loss of interest.

Lack of time
In some organizations many staff are fieldworkers and have little time to participate in workplace policy activities, already starting with development of the workplace policy. They therefore may not be interested in it. Lack of time also concerns some focal point persons, who have very little time left for coordinating workplace policy activities.

Continued feared stigma
Continued feared stigma causes hesitation among staff to disclose their HIV positive status and access care and support from the CSO through the workplace policy. Managers of some CSOs who suspect that there must be some HIV positive staff members, complain that staff are not coming forward to access the care and support offered.

Negative stance on condoms
Especially in FBOs, managers and staff are hesitant to open up discussion of sexuality, particularly when not related to reproduction. FBOs do not acknowledge the risk to their staff for HIV and will not discuss preventive measures other than faithfulness and abstinence. Further, some other CSOs do not want to provide condoms for staff because these are thought not necessary; they would lead to temptation for immoral sex.

No provision of ARVs to staff
If the CSO does not facilitate access to ARV, staff may not be inclined to disclose in the workplace.

6.3 Recommendations

6.3.1 To CSOs

- *Continue with internal awareness raising* on the workplace policy and IEC, focusing on issues which staff would like to know more about; among others related to ART and PMTCT. Refresher training should also be organized regularly because of new staff.
- Provide all *new staff with a copy of the workplace policy,* and explain the contents.
- Start/continue *implementing workplace policy activities that do not require much funds* instead of halting everything waiting for funding. For those just starting the workplace policy process: categorize specific activities in workplace policy to be implemented and accomplished with a clear timeframe and targets, so that those activities requiring less funding can be started while waiting for funds to implement those that are more costly.
- *Link* with services, IEC, and training institutions. Be keen to identify free services.
- Specify the *job description of the focal point person* with attached time allocation.
- *Internally share* what has been gained in the training of individual staff. For instance, internally train more peer educators.

6.3.2 To local project group and project coordinator

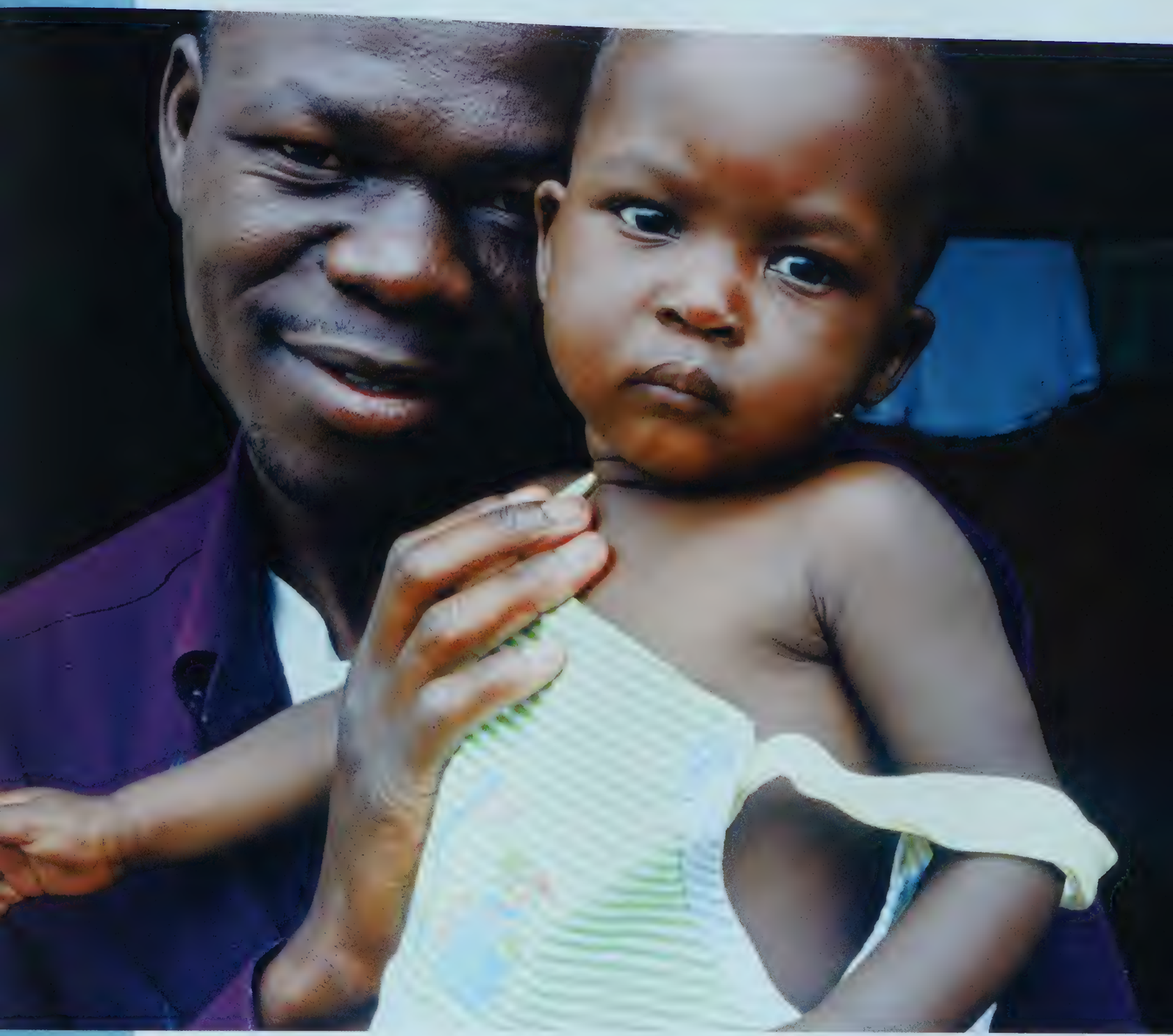
- *Rotate membership of local project group,* with some stable members and some members appointed for two years. This will enhance commitment of participating CSOs.
- Provide *more training to the focal point person of the lead organisation* and possibly funds. They need more facilitation skills to do the supervision and training of the CSOs in their area. A self-reported need by lead organisations was to travel with the project coordinator, because it would be cheaper for them (money being a constraint to visiting their POs) but also for technical support – this being an opportunity for learning from the project coordinator on the job. However, this would defy the idea of installing lead organisations who are supposed to relieve the project coordinator of supervision.
- Call future STOP AIDS NOW! training *training of trainers.* Consider workshops always as train of trainers – staff returning from STOP AIDS NOW! workshops should be trained on how to transfer information and skills received to their peers Organize refresher TOT on topics already covered – because of high staff turnover there is lack of knowledge and skills in some CSOs. Trainees have to make plans for how to disseminate the gained knowledge in their respective CSOs.
- *Continuous sensitization of CSO senior managers and directors.* The local project group chair and project coordinator should personally sensitize and get commitment from new CSO directors (recommendation by local project group chair).
- *Repackage Good Donorship Guidelines and budgeting tool.* Suggestions of the local project group are for STOP AIDS NOW! to see how the tools can be locally owned and made use of. There is a need to repackage the Good Donorship Guidelines and budgeting tool into simpler ones for use by organizations, e.g. CDs, leaflets, posters, etc.
- *Improve use and functions of the information database.* Suggestions made include: 1) try to make it more attractive – for instance on home page give a weekly information update, including links and downloadable reports; and 2) give more feedback to the partner organizations about what they and other organizations are reporting on in the database.

6.3.3 To STOP AIDS NOW! donors (Oxfam Novib, Hivos, Cordaid, and ICCO)

- *Screen submitted budgets* in a timely fashion and *release funds promptly* to allow the Ugandan CSOs to implement their workplace policy programme activities.
- *Initiate new programme managers in workplace policy* at the start of their job, to be done by their superiors, the previous programme manager, or by the STOP AIDS NOW! project coordinator in the Netherlands.
- *Share lessons learnt* and promising practices from this project with other agencies/countries.

6.3.4 To STOP AIDS NOW! and project coordinator

- The Dutch STOP AIDS NOW! project coordinator should be at the forefront to identify, link, and even negotiate for further/continued funding from other donors.
- *Share lessons learnt* and promising practices from this project with other agencies and in other countries.
  - Organizations that have shown exemplary practices could be invited as resource persons in some of the STOP AIDS NOW! workshops to share their experiences.
  - Make the AR documents easily accessible on the STOP AIDS NOW! website and distribute printed copies during relevant conferences and workshops.



6.3.5 To (future) similar projects

Some advice given by the local project group to organizations or consortiums who want to build a similar project structure as that of STOP AIDS NOW! Uganda are the following:

- Membership of local project group to comprise of credible organizations with useful networks and different fields of expertise.
- If the country is too big or partner CSOs too many, install Lead CSOs. These Lead CSOs should also be credible and established organizations with strong networks.
- Create guidelines/MOUs for all the stakeholders in the structure (project coordinator, local project group, lead organisation) and review them periodically.
- Create and sustain links with key people / officers of key institutions, at different levels, national, regional, and local – not only with certain programme officers.
- Involve key stakeholders right from the inception and design stage – share detailed information with clarity, do it periodically. This should include national level stakeholders, e.g. National AIDS Commission, Ministry of Health, ILO, CSO associations, organizations of PLHIV, organizations of employers.

Annex 1: Organizations visited in the three AR phases and for final report

Acronym	Full Name	AR1		AR2		AR3		Final
		Case	Survey	In Depth Interview(s)	Focus group discussion	In Depth Interview(s)	Survey	
ACFODE	Action for Development		•	•				
ACODE	Advocate Coalition for Development and Environment		•	•				
ACORD HASAP	ACORD HASAP		•	•		•	•	
AFR2000N	Africa 2000 Network – Uganda		•	•				
	Akika Embuga			•				
AMAKULA				•				
AMFIU	Association for Micro Finance Institutions in Uganda		•	•		•	•	
AMWAFRI	Akina Mama Wa Afrika		•	•				
BUSO FOU	BUSO Foundation		•	•		•		
CDRN	Community Development Resource Network		•	•		•		
CEEWA-UG	Council for Economic Empowerment for Women of Africa – Uganda		•	•				
CEFORD	Community Empowerment for Rural Development		•	•	•	•	•	
CEREDO	Catholic Education Research Development Organization		•	•	•	•	•	
CERUDEB	Centenary Rural Development Bank			•				
CMB	Catholic Medical Bureau			•				
COMBRA	Community Based Rehabilitation Alliance		•	•				
Concern	Concern Worldwide			•				
COU-SDED	Church of Uganda – Soroti Diocese		•	•	•	•	•	
COU-TEDDO	Church of Uganda – Teso Diocese Planning and Development Office	•	•	•	•	•	•	
CPAU	Concerned Parents Association – Uganda		•	•				
DA	Development Alternatives			•				
DENIVA	Development Network of Indigenous Voluntary Association		•	•				
DETREC	Development Training and Research Centre		•	•	•		•	
EA	Environment Alert			•		•		
EASSI	East African Sub-Regional Support Initiative	•	•	•	•	•	•	•
FAPAD	Facilitation for Peace Development	•	•	•				
FEMRITE	Uganda Women Writers Association		•	•				
FHRI	Foundation for Human Rights Initiatives		•	•		•	•	
FIDA UG.	The Uganda Women Association – Uganda		•	•		•	•	
FOCCAS				•				
	Fort Portal Diocese – Health Department		•	•				
FOWODE	Forum for Women in Development			•				
FURA	Foundation for Rural Advancement	•	•	•	•	•	•	•
HA UG	Hospice Uganda		•	•			•	•
	Health Development Kabale Diocese		•	•				
HN UG	Health Need Uganda	•	•	•	•	•	•	•
IRDI	Integrated Rural Development Initiatives		•	•	•	•	•	

Acronym	Full Name	AR1		AR2		AR3		Final
		Case	Survey	In Depth Interview(s)	Focus group discussion	In Depth Interview(s)	Survey	
JIDDECO	Jinja Diocesan Development Coordinating Organisation			•		•	•	
KADP	Karamodja Agro-Pastoral Development Programme					•	•	
KALI	Karambi Action for Life Improvement – Kasese	•	•	•	•	•	•	
KARUDEC	Kagando Rural Development Centre	•	•	•	•	•	•	
LABE	Literacy and Adult Basic Education	•	•	•	•	•	•	•
LOFP	Lango Organic Farming Production	•	•	•	•			
MADEFO	National Agricultural Movement of Uganda					•	•	
MWODET	Mpigi Women Development Trust		•					
NOGAMU	National Agricultural Movement of Uganda	•	•	•	•		•	
NORRACOL	Northern Rwenzori Rural Community Agriculture and Conservation Link	•	•	•	•			
NORTH-ACORD	ACORD Northern Uganda		•	•	•	•	•	
NUDIPU	National Union of People with Disabilities			•				
NUWODU	National Union of Women with Disabilities in Uganda			•	•	•	•	•
ORUDE	Organization for Rural Development		•	•				
RUCREF	Rural Credit Finance Company		•	•				
RV	Raising Voices		•	•				
SOMED	Support Organization for Micro-Enterprises Development	•	•	•				
SSD	Social Services Development					•		
TAP	TESO AIDS Programme	•	•	•	•	•	•	
TOCINET	Tororo Civil Society Network		•	•		•	•	
TPO UG	Trans-Cultural Psycho-Social Organization		•	•	•		•	•
TTP	Tripartite Training Program		•	•	•			
UCAA	Uganda Change Agent Association			•				
UCRNN NET	Uganda Child Rights CSO Network		•	•				
UCS	Uganda Catholic Secretariat	•	•	•				
UFFCA	Uganda Fisheries and Fish Conservation Association	•	•	•	•		•	•
UFTL	Uganda Finance Trust Limited		•	•				
UJCC	Uganda Joint Christian Council	•	•		•	•	•	
ULA	Uganda Land Alliance		•	•				
UMFL	Uganda Micro Finance Limited		•	•				
UMU	Uganda Martyrs University (Nkozi)		•	•				
UMWA	Uganda Media Women's Association		•	•				
URAA	Uganda Reach the Aged Association		•	•				
USDC	Uganda Society for Disabled Children		•	•				
UWFT	Uganda Women Finance Trust			•				
UWONET	Uganda Women's Network		•	•				
VECO UG	VECO-Uganda		•	•				
VEDCO	Volunteer Efforts for Development Concerns		•	•		•		
VISION-TERUDO	Vision Teso Rural Development Organization		•	•	•	•	•	
WOUGNET	Women of Uganda Network	•	•	•	•	•	•	
Total Numbers		16	60	72	24	29	30	8

Annex 1: Organizations visited in the three AR phases and for final report

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Photography page 41 Roy Beusker, all other pages Adriaan Backer
Print Drukkerij Zwaan printmedia
Published STOP AIDS NOW!
Design Marchien Bart (www.dedirectie.nl)

ENDORSING
NGO CODE OF GOOD PRACTICE

STOP AIDS NOW! aims to expand and improve the Dutch contribution to the global response to HIV and AIDS. In STOP AIDS NOW! five organisations, the Aids Fonds, Hivos, ICCO, Cordaid and Oxfam Novib have joined forces.

STOP AIDS NOW! aims to:

- Raise funds in order to contribute to more HIV and AIDS projects in developing countries
- Obtain political and public support for the efforts against HIV and AIDS, both nationally and internationally
- Innovate or redefine existing strategies and establish new forms of cooperation in order to improve the response to HIV and AIDS, and meet the needs of people affected.

Visit our website for a wide range of downloadable resources on HIV and AIDS in the workplace, including this report:
www.stopaidsnow.org/downloads

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